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BALCONY

January 1981

Journal of the State Medical Association

Mississippi

(ISSN 0026-6396)

Contents:

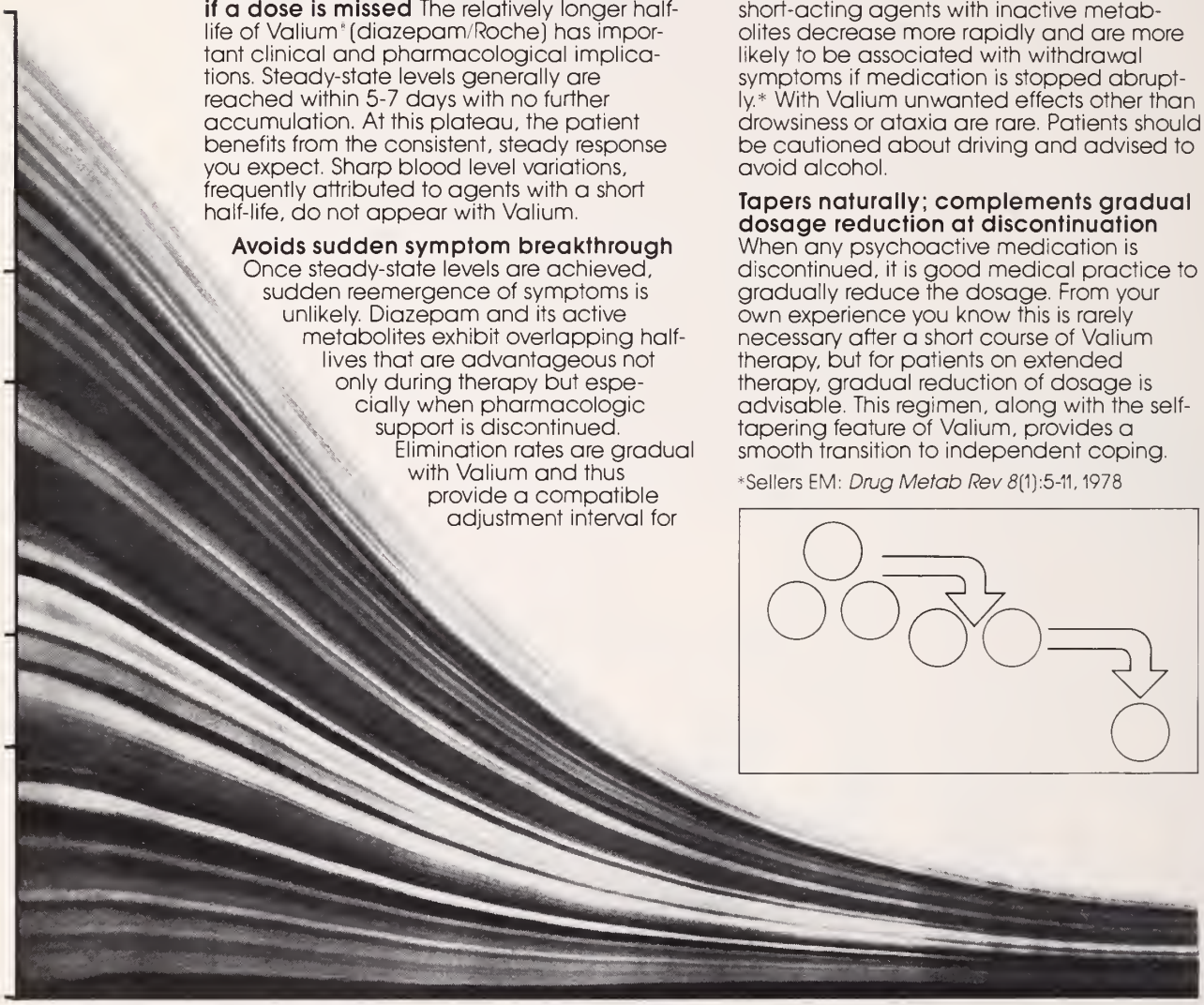
Acromegaly

Diagnostic Ultrasound In the Evaluation of Abdominal Abscess

Transhepatic Portography With Embolization of Varices

half-life

Just one built-in advantage



Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978

in the management of symptoms of anxiety

Valium® (IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

Before prescribing, please see summary of product information on next page

ROCHE®

Valium®
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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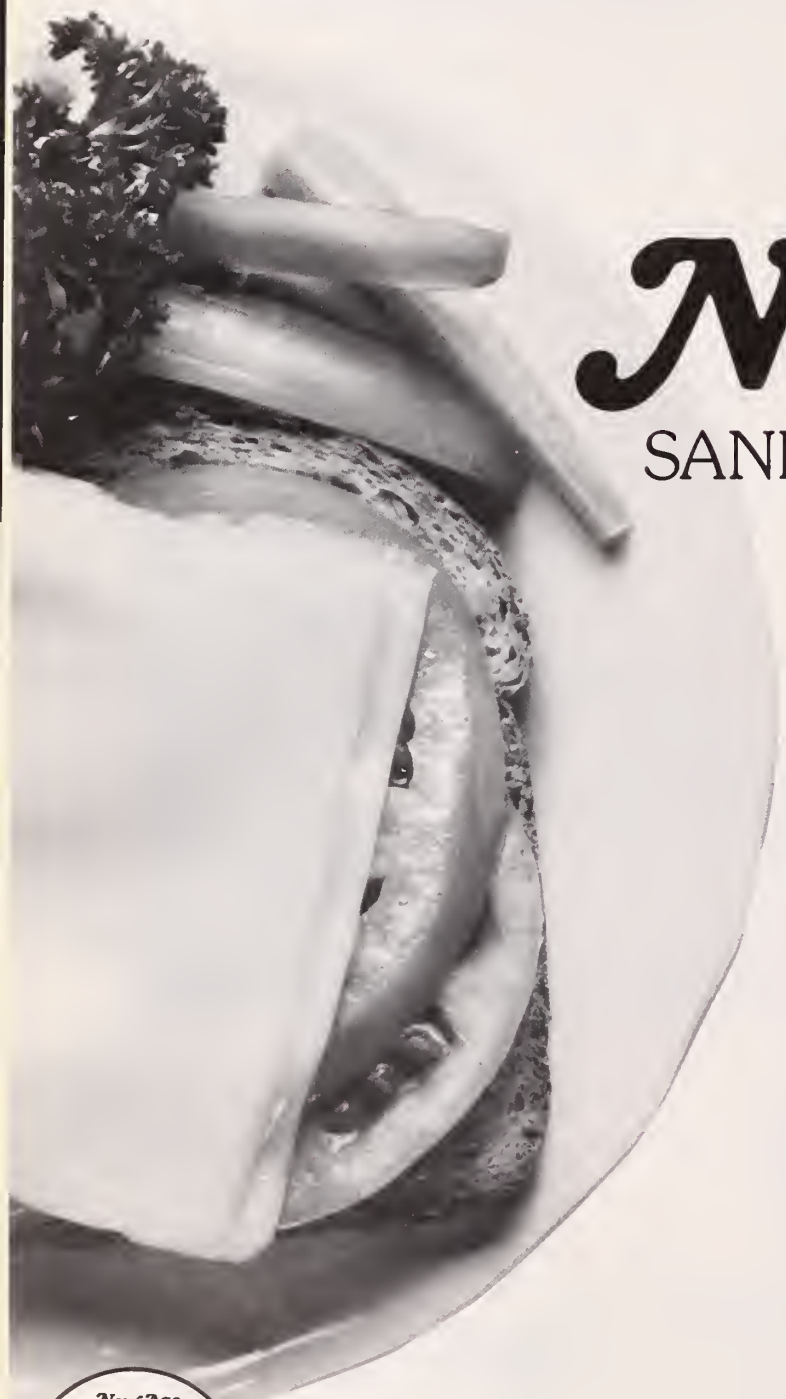


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JOURNAL of the MISSISSIPPI State Medical Association

January 1981, Volume XXII, Number 1

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Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings.)

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED

Bottles of 100 Tablets	NDC 0524-0058-01
Bottles of 500 Tablets	NDC 0524-0058-05

Federal law prohibits dispensing without prescription

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RU-TUSS® EXPECTORANT

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease. Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED

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NEWSLETTER

January 1981

Dear Doctor:

The infant death rate currently is the lowest in U.S. history, according to an article in Pediatrics. The provisional figure of 12.8 deaths per 1,000 live births recorded for the twelve months ending in June 1980, shows a continuing downward trend for infant mortality. The 1979 rate was 13.0 deaths per 1,000 live births, and the 1978 rate was 13.8. By comparison, the rate in 1930 was 64.6 deaths per 1,000 live births.

> Mississippi continues to lead all states in infant mortality (17.8 deaths per 1,000 live births). The District of Columbia's rate is 19.3. The lowest rates occurred in Maine and New Hampshire (each with 10.4). Internationally, the U.S. ranks 16th lowest among 25 nations with populations of 2 million or more.

The AMA will urge the repeal of the Health Planning and PSRO Laws by the 97th Congress, following action of the AMA House of Delegates, which met recently in San Francisco. The delegates urged continued support for professionally directed peer review of the quality and appropriateness of medical services and the elimination of all government directed peer review programs.

Archives of Ophthalmology reports a growing number of eye injuries suffered by racquetball players in the Baltimore area, a trend which is presumed to be indicative of the entire nation, where some 7 million are now playing the sport. The 37 eye injuries in a three month period could have been prevented, said the reporting physician, if the players had worn protective glasses.

Some 100 million persons will be covered by dental insurance in 1985, predicts a benefit plan consulting firm. Presently some 70 million are covered, compared to 2 million in 1965. The popularity of the plans is understandable, says the firm, given the prevalence of dental disease. The ADA estimates that 95% of the population suffer tooth decay and that 18% of adults have lost all their teeth.

The use of alcohol by adolescents may have leveled off, although at a high rate. A survey for the National Institute of Alcohol Abuse and Alcoholism suggests that 80% of high school youth have experimented with alcohol, and 31% are misusers. Nearly 15% are considered heavy drinkers. These are essentially the same percentages reported in a similar survey conducted in 1974.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

POSTGRADUATE CALENDAR

Jan. 29-31, 1981
Advanced Cardiac Life Support
Veterans Administration Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology, the Veterans Administration Medical Center, the Medical Center Division of Continuing Health Professional Education and the American Heart Association, Mississippi Affiliate.

Coordinators: James Griffith, M.D., Veterans Administration Medical Center, and Thomas J. Herrin, M.D., professor of anesthesiology, University of Mississippi School of Medicine.

This program is open to all health professionals who have been certified by the American Heart Association in basic life support and who are actively engaged in advanced cardiac life support on a daily basis. Fee: $125. Credit: 12 contact hours (1.2) CEU, Category I of the Physician's Recognition Award, AMA; American College of Emergency Physicians; American Academy of Family Physicians.

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Jan. 30-31, 1981
Forensic Odontology and Pathology
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Dentistry Department of Oral Pathology and Oral Radiology, the University of Mississippi School of Medicine Department of Pathology, the Medical Center Division of Continuing Health Professional Education and the Office of the Mississippi State Medical Examiner.

Coordinator: Sigurds O. Krolls, D.D.S., professor of oral pathology and oral radiology and chairman of the department, University of Mississippi School of Dentistry, and professor of pathology, University of Mississippi School of Medicine.

This seminar will include discussions of means of identification dealing with specific and general principles of evidence evaluation. Presentations will emphasize recognition of bite marks and the battered child syndrome. Fee: $50. Credit: 10.5 contact hours (1.05 CEU) Category I of the Physician's Recognition Award, AMA.

Feb. 5-6, 1981
Renal Update
Coliseum Ramada Inn, Jackson

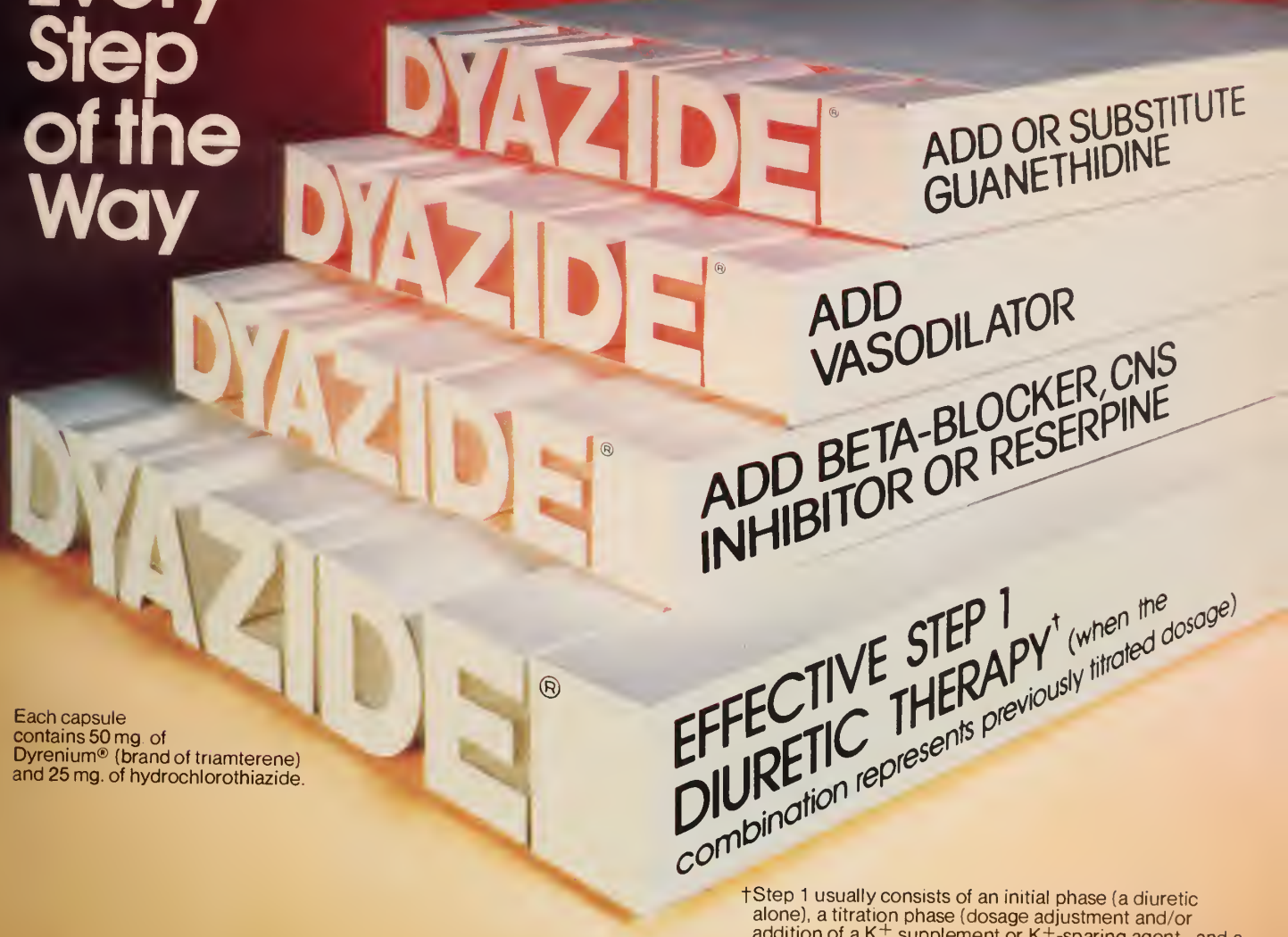
Sponsored by the University of Mississippi School of Medicine Department of Medicine, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education. Co-sponsors are Kidney Care, Inc., the Kidney Foundation of Mississippi, the Mississippi Nephrologic Society and the Mississippi Urologic Society.

Coordinator: John D. Bower, M.D., professor of medicine, assistant professor of physiology and biophysics and director, Artificial Kidney Unit, University of Mississippi Medical Center.

This program is a joint conference for physicians, nurses, social workers and dietitians. The physicians' program is designed for the family practitioner, internist and urologist. The faculty will review the physiology and pathophysiology of fluid, electrolytes, and acid-base balance and discuss clinical problems associated with nephrologic disorders. Fee: $50 for physicians. Credit: 11.5 contact hours (1.15 CEU) Category I of the Physician's Recognition Award, AMA.

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†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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With Limbitrol, patients often improve within a week. Not only is insomnia relieved, but you will often see early relief of agitation, psychic and somatic anxiety, anorexia and feelings of guilt or worthlessness. This early response encourages patients to stay in therapy.

You can minimize phenothiazine drawbacks

When you choose Limbitrol over a phenothiazine-containing product, you minimize the risk of tardive dyskinesia – now associated even with low dose, short-term phenothiazine therapy.[1,2] You also reduce the possibility of other extrapyramidal side effects, which occur in approximately 30% of patients receiving phenothiazines.[3-5] In contrast, the reported incidence of these disturbing reactions with Limbitrol or either of its components alone is rare. (For a complete list of side effects reported with Limbitrol, please consult full disclosure.)

References: 1. Poulson GW. *NY State J Med* 79:193-195, Feb 1979. **2.** Hollister LE. Antipsychotic medications and the treatment of schizophrenia, chap. 9, in *Psychopharmacology from Theory to Practice*, edited by Barchas JD, *et al*. New York, Oxford University Press, 1977 pp 134, 145. **3.** Domino EF. Antipsychotics: phenothiazines, thioxanthenes, butyrophenones, and rauwolfia alkaloids, chap. 25, in *Drill's Pharmacology in Medicine*, ed.4, edited by DiPalma JR. New York, McGraw-Hill Book Company, 1971, p.476. **4.** Sovner R, DiMascio A. Extrapyramidal syndromes and other neurological side effects of psychotropic drugs, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p.1021. **5.** Donlon PT, Stenson RL. *Dis Nerv Syst* 37: 629-635, Nov 1976.

ROCHE®

SAFETY/BENEFIT RATIO



What better reason to choose Limbitrol for your patients with moderate depression and anxiety?

Limbitrol® 5-12.5 10-25

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)



Efficacy without a phenothiazine

Please see summary of product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy.

Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male; breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) – bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

ROCHE®

ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

Your guide to patient management... when you decide medication is needed

How to initiate and maintain therapy

Select dosage strength appropriate for each patient

- Limbitral 5-12.5 is recommended to minimize drowsiness and for elderly patients
- Limbitral 10-25 may be indicated for patients who tolerate medication without undue side effects

Specify daily dosage based on symptom severity

- An initial dosage of three tablets is recommended
- Dosage may be increased to six tablets or decreased to two tablets daily as necessary
- Once a satisfactory response is obtained, patients should be continued on the smallest dose required to maintain the desired effect

Utilize dosage options to best accommodate individual patient needs

- T.I.D. or Q.I.D., familiar regimens most suited for patients who tolerate medication without undue drowsiness
- Two tablets one hour before bedtime and one tablet midday may minimize daytime drowsiness and help relieve a common target symptom – insomnia
- Entire dosage h.s. to take maximum advantage of the sedative effect

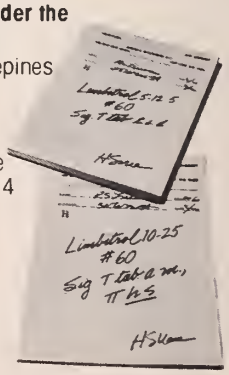
How to make each patient an informed patient

1. Discuss with patients the probability that they will experience drowsiness, especially during the first week.
2. Reassure your patients that drowsiness is one indication that the medication is working and that it may help alleviate their insomnia.
3. Encourage patients to report if drowsiness becomes troublesome so that, if necessary, dosage schedule can be adjusted.
4. Caution patients about the combined effects with alcohol or other CNS depressants. Let them know that the additive effects may produce a harmful level of sedation and CNS depression.
5. Caution patients about activities requiring complete mental alertness, such as operating machinery or driving a car.
6. Warn pregnant patients and patients of childbearing age that the safety of Limbitrol in pregnancy has not yet been established.

Please see complete product disclosure for other pertinent information.

Limbitrol should not be used under the following circumstances:

1. Hypersensitivity to benzodiazepines or tricyclic antidepressants.
2. Concomitantly with an MAO inhibitor. To replace an MAO inhibitor with Limbitrol, discontinue MAO inhibitor for a minimum of 14 days before cautiously initiating Limbitral therapy.
3. During the acute recovery phase following myocardial infarction.



In moderate depression and anxiety

Limbitrol® IV

Relief without a phenothiazine

More physicians *are coming to MMFES because MMFES does more for physicians.*

The active and involved physician has to rely on comprehensive insurance programs tailored to fit the day-to-day special needs of his profession.

One of these special needs is malpractice insurance. MMFES is a non-profit Mississippi Corporation sponsored by the Mississippi State Medical Association and directed by Mississippi physicians. MMFES offers comprehensive coverage on three types of malpractice insurance policies and it'll probably cost you less than other plans.

Mike Houpt is aware of your special need. Give him a call toll free at 1-800-682-6415 or 944-0072.

MMFES

"The people to see for Malpractice Insurance"

MISSISSIPPI MEDICAL FRATERNAL AND EDUCATIONAL SOCIETY

735 Riverside Dr. • Box 4625 • Jackson, Ms. 39216 • 944-0072

Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness, emotional problems, or substance abuse, it is the only hospital of its kind in the state.

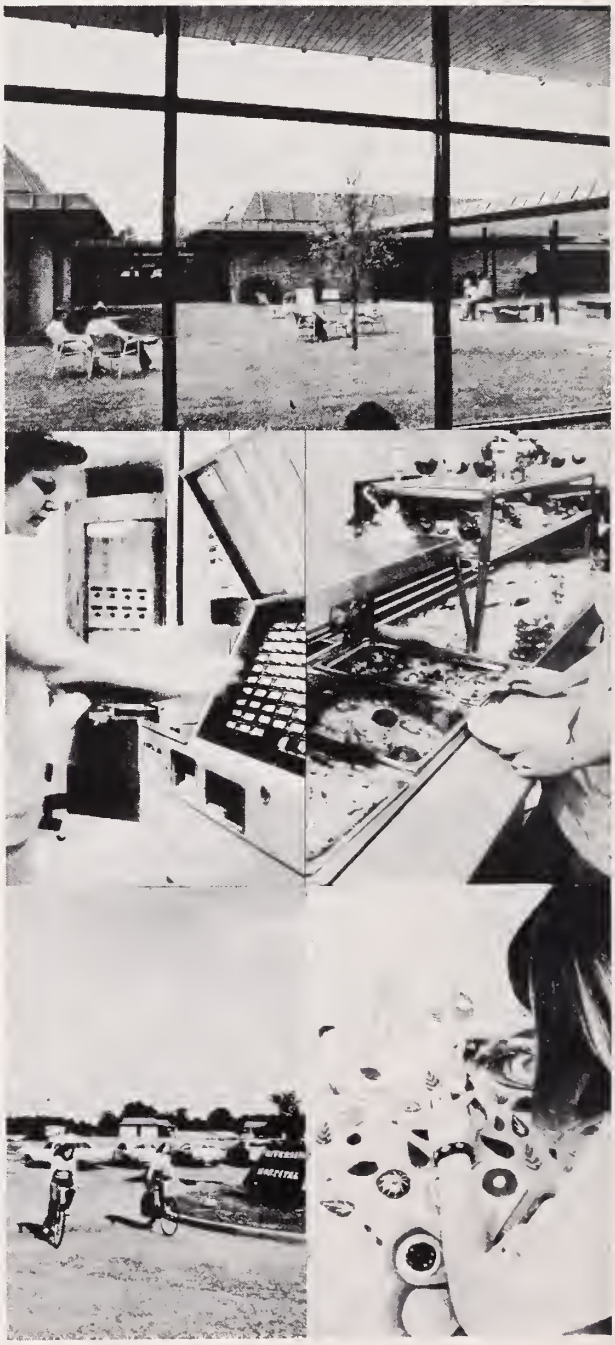
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601)939-9030

DATELINE

Malpractice Seminar Next Month

Jackson, MS - "Malpractice in Mississippi: A Medical and Legal Perspective," a seminar co-sponsored by MSMA and MMFES, will be held Saturday, Feb. 7, at the Coliseum Ramada Inn in Jackson. Registration fee is $40. Enrollment will be limited to 200. Reservations may be made by calling 1-800-682-6415. A faculty of medical and legal speakers will present discussions of various aspects of malpractice. The seminar is accredited for six hours Category I of the AMA Physicians Recognition Award.

Note Upcoming MSMA Events

Jackson, MS - MSMA members are reminded of two other important dates in the 1981 MSMA calendar: January 28 is the date for the Auxiliary's "Day With the Legislature" at the Downtown Holiday Inn in Jackson, with Gov. Winter, Lt. Gov. Dye, Speaker of the House Buddie Newman and Mississippi legislators as special guests; and April 26 marks the beginning of MSMA's 114th Annual Session, with 14 scientific section programs, meetings of the House of Delegates, and specialty society meetings.

UMC Produces PR Film

Jackson, MS - "The Home Team: A Report from the University of Mississippi Medical Center" is a 16mm film documentary about the health sciences campus. The 19 minute film is available for use by organizations. It details the institution's education mission in Mississippi and explains some of the special patient care and research programs underway at UMC. To borrow the film, contact the Department of Public Relations, UMC, 2500 North State St., Jackson, MS 39216.

Pediatricians Urge New Priorities

Chicago, IL - The American Academy of Pediatrics has called on President-elect Reagan to make improved maternal and child health care a top health priority. Specific recommendations include the reorganization and integration of federal programs which affect child health, revisions in Medicaid, and expanded research. The AAP urges the creation of a new Maternal and Child Health Administration to consolidate more than 100 child health programs now under different federal agencies.

Cost Effectiveness Program Planned

Chicago, IL - An AMA action program on cost effectiveness gets underway early this year. The program will stress promotion of state, county and specialty society cost containment efforts, documentation of the impact of these projects, and increased dissemination of information. Workshops are planned, medical staff projects will be evaluated through a network of about 75 hospitals, and four new pamphlets will be published to assist the public in becoming cost conscious.



Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX®.

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS
(mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

© Janssen Pharmaceutica Inc. 1980 JPI-023



Broad-spectrum coverage in mixed helminthic infections

TABLETS
Vermox®
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

Hypertension Program Wins Public Health Award

Washington — The National Heart, Lung and Blood Institute received a special public health award from the Albert Lasker Medical Research Foundation for its Hypertension, Detection and Follow-up Program.

Dr. Herbert Langford, professor of medicine at the University of Mississippi Medical Center, served as chairman of the national HDFP steering committee. Fourteen Medical Centers and 11,000 Americans participated in the five-year study which proved conclusively the lifesaving value of treating mild high blood pressure.

Prior to the landmark study, there was little hard data to indicate the need for treating mild hypertension.

New Orleans Will Host Clinical Nutrition Congress

The American Society for Parenteral and Enteral Nutrition will hold its Fifth Clinical Congress at the New Orleans Hilton, Feb. 2-5.

ASPEN is a multi-disciplinary society consisting of medical doctors, doctors of science, dietitians, pharmacists and nurses in the field of contemporary clinical nutrition.

Theme of the Congress is "The Challenge of Modern Clinical Nutrition: Education, Practice and Research." Symposium and short paper sessions, scientific exhibits and information exchange sessions will present advances in clinical nutrition.

For registration information contact ASPEN, 1025 Vermont Avenue, NW, Suite 810, Washington, DC 20005.

Surgical Congress Sets 49th Annual Assembly

The Southeastern Surgical Congress will hold its 49th Annual Assembly Feb. 22-25, 1981, at the Fairmont Hotel in New Orleans. There are 27.75 hours of Category I credit available for this program.

On the opening day, eight hours of credit will be offered for a postgraduate course entitled "Cancer Therapy Update."

For more information contact Southeastern Surgical Congress, 315 Boulevard, NE, Suite 500, Atlanta, GA 30312.

Announcing a major symposium for primary care physicians

Anxiety: the therapeutic dilemma



National authorities offer views and insights Are minor tranquilizers overused? Is anxiety overdiagnosed? Do antianxiety drugs create other clinical problems? What are the alternatives?

These and other critical questions will be examined in a one-day symposium and workshop at the Tulane Medical Center, New Orleans, on February 14, 1981. Eminent physicians will discuss aspects of treatment including (1) recognition and management of the dependence-prone patient, (2) ways to minimize tranquilizer dependency, (3) current information on the biochemistry of anxiety and (4) how it can affect treatment modalities.

Unique interactive format offers direct participation Filmed case presentations provide source material for participant interaction — to demonstrate keys to differential diagnosis and clarify guidelines for selecting appropriate drug and nondrug therapies.

Program Topics and Faculty

The Clinical Spectrum of Anxiety	Michael J. Halberstam, MD, Private Practice, Internal Medicine and Cardiology, Washington, DC; Editor, Modern Medicine; Associate Clinical Professor of Medicine, George Washington University Medical Center
Anxiety: Etiology and Dynamics	Sidney L. Werkman, MD, Professor of Psychiatry, University of Colorado School of Medicine
Differential Diagnosis of Anxiety	Robert E. Rakel, MD, Professor and Head, Department of Family Practice, The University of Iowa College of Medicine
The Problem of Drug Dependence	David H. Mielke, MD, Associate Professor of Psychiatry, Tulane University School of Medicine
Pharmacology and Pharmacokinetics of the Minor Tranquilizers	Leo E. Hollister, MD, Professor of Medicine, Psychiatry and Pharmacology, Veterans Administration Medical Center and Stanford University School of Medicine
Benzodiazepine Receptors	Solomon H. Snyder, MD, Chairman & Professor, Department of Neuroscience, Distinguished Service Professor of Neuroscience, Psychiatry and Pharmacology, The Johns Hopkins University School of Medicine
Management Approaches to the Patient With Anxiety	Julius Michaelson, MD, Past President, American Academy of Family Physicians
Tranquilizers: Guidelines for Appropriate Use	Robert E. Rakel, MD, Professor and Head, Department of Family Practice, The University of Iowa College of Medicine
Non-Drug Treatment Alternatives	Sidney L. Werkman, MD, Professor of Psychiatry, University of Colorado School of Medicine
	Other members of the symposium faculty, from the Tulane University School of Medicine, include John W. Goethe, MD and Daniel K. Winstead, MD.

Eight credit hours in Category 1 for PRA/AMA, Prescribed hours by AAFP, Category 2-D of AOA and/or Formal Learning cognates of ACOG will be awarded.

Anxiety: The Therapeutic Dilemma is being produced in collaboration with Tulane University School of Medicine, Department of Psychiatry and Neurology, by M.E.D. Communications, under an educational grant from Abbott Laboratories.

A

Office of Continuing Education, Tulane Medical Center,
1430 Tulane Avenue, New Orleans, Louisiana 70112.

Please send full information about the symposium
Anxiety: The Therapeutic Dilemma.

Name _____
(please print)

Title _____

Address _____

City _____ State _____ Zip _____

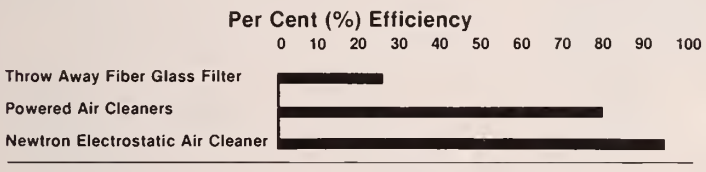
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Doctor, your patients will be asking about the Newtron® Electrostatic Air Cleaner.



And with good reason. The Newtron® electrostatic air cleaner is a revolutionary new device that allows allergy patients to breathe clean air in their homes and offices — at a much lower cost than has ever been possible before.

In fact, the Newtron® is the only reasonable answer to the problems caused by pollen, dust, smoke, and other air pollutants. It requires no electricity, never needs to be replaced, requires no maintenance other than a monthly rinsing with tap water, and comes in standard filter sizes to simply replace the existing throw-away filter in heating and air conditioning systems. Even more importantly, it far out-performs all other cleaners, including electrically powered models costing more than three times as much.



In the past, high costs and complicated installation have put truly clean air out of the reach of most allergy patients. Now that the Newtron® is available — and has been proven effective in hospitals, businesses, private homes, and apartments — your patients will be asking for your approval or opinion.

Please allow us to send you a complete information package on the Newtron®. No salesman will call, either in person or by telephone (unless you request it). The price of the Newtron® varies from $195 to $205, according to size. (Master Charge® and VISA® are accepted.) Professional discounts on Newtron® electrostatic air cleaners are available to physicians who wish to purchase one unit for their personal use.

Newtron®

The ultimate air cleaner.

Clip and mail this coupon to

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202 Nottingham Ln.
Slidell, La. 70458

Please send complete information on the Newtron® electrostatic air cleaner.

Dr. _____

Address _____

City _____ State: _____

Zip: _____

Specialty: _____

Newtron® is a registered trademark of Newtron Products Co., Cincinnati, Ohio
The generic name is electrostatic air cleaner

MULTIDISCIPLINARY MICROSURGERY AT THE MARDI GRAS NEW ORLEANS, LOUISIANA

AN IN-DEPTH CONFERENCE IN MULTIDISCIPLINARY PROBLEM SOLVING UTILIZING MICROSURGICAL TECHNIQUE

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IN CONJUNCTION WITH
LOUISIANA STATE UNIVERSITY
SCHOOL OF
MEDICINE



Seminar I
February 25—March 2, 1981
Seminar II
February 27—March 2, 1981
Mardi Gras Day
March 3, 1981

Topics:

Basic Microscope Techniques
Setting Up a Lab
Acute Management of the Multiple Trauma Candidate Requiring Reimplantation
Esophageal Reconstruction with Vascularized Jejunal Interposition
Head and Neck Reconstruction Via Microsurgery
Mandibular Reconstruction with Vascularized Bones and Soft Tissues
Toe to Hand Transfers
Cancer and Microsurgery
Geometry of and Planning of Microsurgery Free Flaps
Bracheal Plexus and Peripheral Nerve Microsurgery
Intracraneal Neuromicrosurgery
Urologic Microsurgery, Including Reconstructive, Replantation and Infertility
Gynecological Microsurgery Reconstruction and Infertillty
Chest Wall Reconstruction with Microsurgery
Microsurgery and Trauma
Orthopedic Applications of Microsurgery
Microsurgery

Program:

The course consists of two seminars
Seminar I A lab and alecture series, Wednesday February 25 through Monday, March 2.
19 hours lecture and 21 hours lab, which includes basic techniques with personalized instruction from visiting faculty using Applied Fiberoptics binocular microscopes.
Seminar II A lecture and video series. Friday, February 27 through Monday, March 2
19 hours lecture and simultaneous video sessions to coincide with the labs

Accreditation:

As an organization accredited for continuing medical education, Louisiana State University School of Medicine, New Orleans, designates this continuing medical education activity as meeting the criteria for forty credit hours in Category I of the Physician's Recognition Award of the American Medical Association

Registration:

Tuesday, February 24, 1:00—4:00 PM
Daily from 7:00 AM
A registration fee of $600.00 for Seminar I, or $300.00 for Seminar II should accompany the registration form
There is a $50.00 cancellation fee for withdrawals after February 11, 1981. All refunds must be requested in writing and postmarked no later than February 20, 1981 ***Residents half fee.***

Inquiries:

Multidisciplinary Microsurgery at the
Mardi Gras
Southern Baptist Hospital
2700 Napoleon Avenue
New Orleans, Louisiana
(504) 899-9311

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Roche Products, Inc
Manati, Puerto Rico 00701



Acute pain is no laughing matter.

The first prescription for the first days of acute pain

Empirin® c̄ Codeine #3

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). Ⓒ III

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin c̄ Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming.) Ⓒ III

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of not-large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with those of other CNS depressants. See WARNINGS.

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ORIGINAL PAPERS

Acromegaly

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THE RELENTLESS PROGRESSION of the disease process of acromegaly results in grotesque disfiguration, severe disabilities and even death in its victims. Though clinically described as early as 1886 by Marie and pathophysiologically defined by Davidoff in 1926, this disease continues to challenge physicians diagnostically and therapeutically. The treatment objective of acromegaly is the irradiation of the offending pituitary tumor with normalization of the growth hormone levels without deficit of other pituitary functions. Optimal results depend on early diagnosis and initiation of therapy before advanced cosmetic, metabolic and vascular changes have occurred.

CLINICAL SYNDROME

The clinical syndrome of acromegaly is classically caused by the excessive production of growth hormone from an eosinophilic pituitary adenoma. This abnormal hormone production leads to a marked skeletal overgrowth as well as an increase in soft connective tissue mass. If the tumor becomes hormonally active before epiphyseal closure, then a disproportionate growth of the extremities occurs, resulting in the development of a very tall patient, and gives rise to a condition termed gigantism. However, if the neoplasm arises after closure of the epiphysis, then bones in the face, hands, feet, as well as membranous bones, are involved, and in these cases the condition is termed acromegaly. This growth in the post pubertal individual is so insidious that the patient, his family and even his physician may not notice the gradual changes in facial and bodily features.

The first manifestations of these developments to the patient are usually increases in hat, ring, glove or shoe size. The physical appearance is altered by the characteristic progressive thickening of the soft tissues of the face, ears, lips, accompanied by enlargement of the nose and tongue.

Major advances in the diagnosis and management of acromegaly have occurred in the past ten years. The current concepts in evaluating these patients as well as the available therapeutic options are reviewed in this article. The author concludes that transsphenoidal removal of a circumscribed adenoma is both an effective and safe mode of treatment. Optimal surgical results depend on the early recognition of this disease as well as the technical proficiency of the neurosurgeon.

Osseous changes are manifest by a marked prominence of the forehead, prognathic mandible, osteoarthrosis and an abnormal vertebral overgrowth resulting in a progressive kyphosis. Arthralgias, myopathies, and entrapment neuropathies, especially of the median nerve at the carpal tunnel, are frequently noted. In 25% of patients, diabetes mellitus develops with overt symptoms of polyphagia, polydipsia and polyuria.

Usually endocrinopathic changes are seen before visual field deficits, but the reverse may occur especially in cases of pituitary apoplexy. Bitemporal hemianopsia or quadrantanopsia are the common visual field deficits seen with compression of the optic chiasm. Non-specific headaches in these patients are more likely due to traction on pain sensitive

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structures in the dura of the diaphragm sella or cavernous sinus rather than increased intracranial pressure.

Life expectancy in these patients is decreased due to the development of hypertension and congestive heart failure secondary to cardiomegaly or acromegalic cardiomyopathy. In some cases, when the adenoma outgrows its own blood supply and infarcts, the patient is clinically left deformed and metabolically in panhypopituitarism.

Laboratory Evaluation

The definitive diagnosis of acromegaly relies on the determination of excessive growth hormone secretion. Normal growth hormone levels are usually below 5 ng/ml. In patients with acromegaly, these values usually range between 20-50 ng/ml but hormone levels in the hundreds are not infrequent. Since random values may overlap into the range of normal, it is of crucial importance that the absolute level of growth hormone be assayed in the baseline fasting situation as well as documenting its response to provocative studies.

A family of insulin-like peptide growth factors are believed to mediate the effects of growth hormone on cartilage and other skeletal tissues. Radioimmunoessays of these somatomedins have recently[1] been reported to provide a more sensitive and reliable means of documenting the clinical activity of acromegaly. These findings may considerably alter our understanding of the biochemical physiology of acromegaly.

Studies that are commonly utilized to define growth hormone secretory dynamics include insulin provocation, arginine infusion and glucose tolerance test. With an insulin test, hypoglycemia is usually induced causing an elevation of growth hormone in the normal patient, whereas those who have a deficiency in this hormone will have minimal or no change in baseline values. Hyperinsulinism has been detected in approximately 60-70% of acromegalic patients. L-arginine stimulation will cause a stimulatory effect in growth hormone levels in normal patients and a similar lack of response in patients deficient in growth hormone. In patients suspected of having acromegaly, the glucose suppression test has been most useful. In a normal individual, a 100 gram glucose load orally administered suppresses the serum level of growth hormone below 5 ng/ml, whereas in acromegalics this suppression does not occur presumably due to the tumor cells' insensitivity to glucose.

It is not uncommon for acromegaly to be associated with hyperprolactinemia. Prolactin determinations are useful in documenting this hormonal imbalance and have been indicative of large pituitary tumors. An interference in the production or secretion of prolactin inhibitory factor could explain the excessive prolactin secretion in some of these tumors.

Adrenal, gonadal and thyroid function studies should also be performed as well as an assessment of pituitary-target releasing hormones. Documenting hormonal deficiencies enables the clinician to monitor the therapeutic efficacy of the selected mode of treatment and may indicate the necessity of replacing vital hormones such as cortisol.

Radiologic Evaluation

Radiological signs of acromegaly include thickened heel pads (greater than 22 mm) as well as increases in the sesamoid index and hand volume index. However, the enlarged sella turcica is of greater practical importance. On plain skull x-rays, 80% of sella turcicas will be abnormal in acromegalic patients. The evaluation of the sella is most completely performed by hypocycloidal polytomography with cuts at 2 mm intervals in both the anterior-posterior and lateral projection. Acromegalics will have abnormal sellas in 98% of cases[2] and these can be classified in four types as shown in Figure 1.

Pneumoencephalography is not necessary in most cases of acromegaly. With computerized axial tomography augmented by coronal sections and metrizamide cisternal visualization, suprasellar tumor extensions and their relationship to the surrounding structures can usually be documented. Pneumoencephalography, CT scan, or metrizamide cisternography should be performed in the patient with an enlarged sella turcica, but without endocrinologic abnormality to demonstrate an "empty" sella or a non-secretory intrasellar mass lesion.

CLASSIFICATION OF SELLAE

(from Vezina and Maltais)

Type I	Sella of normal shape and size with limited monolateral bulging of the floor within the sphenoid sinus
Type II	Volumetrically enlarged sella with normal outline
Type III	Enlarged sella with destructive changes limited to sella floor
Type IV	Extensive sella destruction

Figure 1: Classification of sellae.

Treatment of Acromegaly

The primary goal in the treatment of acromegaly is to cause a reduction in growth hormone secretion to normal levels, without causing insufficiency of other pituitary functions. Medical management, surgery and radiation therapy, alone or in combination, are the most commonly utilized therapeutic modalities.

Several drugs have been shown to inhibit the secretion of growth hormone including progesterone, chlorpromazine, L-dopa, somatostatin and bromocriptine. The long-term management of acromegaly by these pharmacological agents, especially bromocriptine has been successful in causing clinical and hormonal improvement. However, this therapy does not eradicate the initial problem of a tumor present in the sella turcica, and progressive tumor growth on bromocriptine therapy has been documented.[3] An intrasellar tumor in such instances may progress to cause the development of cerebrospinal fluid rhinorrhea by eroding through the sella floor. Visual field deficits, increased intracranial pressure, or pituitary apoplexy with subarachnoid hemorrhage and hypopituitarism can also occur with progressive tumor growth.

Radiation therapy in the past has been advocated as the initial treatment of pituitary tumors.[4] In acromegaly, conventional radiotherapy will decrease growth hormone secretion in approximately one-third of patients. Interstitial irradiation with ytrium 90 has been noted to be effective in about 50% of cases, but this therapy is limited to tumors of regular contour that have not eroded adjacent structures. Heavy particle radiation by either proton or alpha particles has been demonstrated to be effective in 85-90% of patients, but these techniques are available in only two centers in this country. A prolonged period of two to nine years is necessary for the full effects of radiation therapy. A hazard of radiation is the possibility of radionecrosis of the normal adjacent pituitary, cranial nerves and brain. Infrequent, but no less disturbing, are those cases of malignant tumors developing in the vicinity of radiated tissues 10 to 30 years later.

Surgery for pituitary tumors in the past had generally been advised for decompression of extensive suprasellar lesions. Classically, intracranial surgery via the frontal route had been espoused as the procedure of choice for these large lesions. In most instances, the normal pituitary could not be preserved and adjunctive radiation therapy was utilized.

The transsphenoidal approach to the pituitary is certainly not a new technique since it was used as early as 1907 by Schloffer. The present day revival of this technique occurred as a direct result of the introduction of the microscope to neurosurgery. Utilizing televised fluoroscopy to guide the surgeon to the sella turcica, and with the aid of microsurgical techniques, the resection of an adenoma and preservation of the normal pituitary is usually accomplished. This extracranial approach to the pituitary is relatively non-traumatic and provides an accuracy of operation and dissection that is necessary to achieve a selective microadenomectomy as shown in Figure 2.



Figure 2. Selective adenomectomy with preservation of the normal pituitary.

Surgical Pathology

The acromegalic patient is often difficult to intubate because of the large tongue and epiglottis. The initial exposure of the transseptal transsphenoidal approach in an acromegalic can challenge the most experienced surgeon. Mucosal and bony overgrowth are commonly encountered, and considerable bleeding may develop from the mucosal blood vessels.

In cases where the tumor is large, its identification intraoperatively is not difficult. But in microadenomas (1 cm or less in size), the neurosurgeon must carefully scrutinize the intact gland to detect these small tumors. Hardy[4] has noted that various types of hypersecreting microadenomas tend to be located within specific areas of the pituitary gland. In growth hormone secreting microadenomas, the tumors seem to be predominately located in the anterior inferior lateral aspect of the gland. In some instances of invasive tumors, intradural tumor cells have been identified. Total excision in those cases is very difficult.

Frozen section biopsies to verify the completeness of tumor resection are performed during every case.

By light microscopy, the histological classification of most pituitary tumors in acromegaly will be eosinophilic adenomas. The electron microscope allows a more accurate assessment of these tumors since the size of the secretory granules are characteristic of specific activity.

Results

An immediate and dramatic result of completely resecting an adenoma for acromegaly is the normalization of the growth hormone level. Many recent reports[5, 6, 7, 8, 9, 10] have documented that these results can be expected in 85-90% of cases (see Figure 3). In larger tumors, the surgical results have not been as successful. These larger tumors tend to be more invasive and therefore less amenable to complete resection. In these cases, the persistence of a postoperative elevated hormone level is probably due to residual oversecreting tumor tissue within the sella. Theoretically reexploration of the sella and further tissue resection would be advised, but a radical excision of the sella contents in these patients has not necessarily resulted in a cure.[7]

The acromegalic patient who has had a total tumor resection, will clinically note the diminution of pain from entrapment neuropathy and arthritis as well as the early regression of excessive soft tissue. It is not unusual for patients to comment on these changes as early as the first or second postoperative day. Changes in facial features, weight loss, and a decrease in acral changes can also be expected during the early convalescent period.

RESULTS OF TRANSSPHENOIDAL SURGERY IN ACROMEGALY

Recent Published Series		Number of Patients	Cure Rate			
			Intrasellar adenomas		Invasive adenomas	
Arafad, et al	1980	28	12/12	(100%)	8/16	(50%)
Hardy	1979	120	63/77	(81.8%)	31/43	(72%)
*Laws, et al	1979	71	13/17	(76%)	20/54	(37%)
*U, et al	1977	38	10/12	(83%)	20/26	(78%)
Decker, et al	1976	14	4/5	(80%)	5/9	(55%)
Jaquet, et al	1976	14	6/9	(66%)	3/6	(50%)
Totals		285	108/132	(81.8%)	87/154	(56%)

* Selected previously untreated patients

Figure 3: Results of transsphenoidal surgery.

During surgery and in the immediate postoperative period, these patients are treated with prophylactic antibiotics and cortisone. Replacement hormones are rarely indicated since the normal pituitary can usually be spared. As opposed to hypophysectomy, in selective adenomectomy the diaphragm sella is not usually perforated and the occurrence of CSF rhinorrhea and meningitis is therefore very unusual. Diabetes insipidus may occur but is usually transient in duration.

On the basis of the recently reported surgical results, the initial treatment of choice in acromegaly should be transsphenoidal microsurgery, provided that the neurosurgical expertise in the use of this procedure is available. ★★★

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References

1. Clemmons, D. R., Van Wyk, J. J., Ridgway, E., Klimon, B., Kgellberg, R. N., and Underwood, L. E.: Evaluation of acromegaly by Radioimmunoassay of somatomedia-C. N. E. J. M. 301:1138-1142 (1979).
2. Vezina, J. L., et Mattaris, R.: La selle turcique dans l'acromegalie, etude radiologique Neurochirurgie 19 (Suppl. 2:35-56) (1973).
3. Salti, I. S., and Istfan, N.: Bromocriptine fails to stop growth of eosinophilic adenomas in acromegaly. N. E. J. M. 301:386 (1979).
4. Hardy, J., Somma, M., Vezina, J. L.: Treatment of acromegaly: Radiation or surgery? Current Controversies in Neurosurgery, Morley, J. P. (Ed) W. B. Saunders Co., Philadelphia, pp. 377-391 (1976).
5. Arafab, M. M., Brodkey, J. S., Kaufman, B., Velasco, M., Manni, A., and Pearson, O. H.: Transsphenoidal microsurgery in the treatment of acromegaly and gigantism. J. Clin. Endocrinol. Metab. 50:578-585 (1980).
6. Decker, R. E., Epstein, J. A., Carras, R., and Rosenthal, A. D.: Transsphenoidal microsurgery for pituitary tumors: Experience with 45 cases. Mt. Sinai J. Med. 43:565-577 (1976).
7. Hardy, J., and Somma, M.: Acromegaly: Surgical treatment by transsphenoidal microsurgical removal of the pituitary adenoma. Clinical Management of Pituitary Disorders, Tindall, G. T., and Collins, W. F. (Ed) Raven Press, New York, pp. 209-217, (1979).
8. Jaquet, P., Grissoli, F., Guibout, M., et Lissitzky, J. C.: Resultats de l'exerese' chirurgicale par voie transsphenoidale dans 30 cas d'adenomes hypophysaires hypersecretants. Annal d' Endocrinol. (Paris) 37:283-284 (1976).
9. Laws, E. R., Piepgras, D. G., Randall, R. V., and Abbound, C. F.: Neurosurgical management of acromegaly. J. Neurosurg. 50:454-461 (1979).
10. U, H. S., Wilson, C. B., and Tyrrell, J. B.: Transsphenoidal microhypophysectomy in acromegaly. J. Neurosurg. 47:840-852 (1977).

Diagnostic Ultrasound in the Evaluation of Abdominal Abscess

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THE DOCUMENTATION of a clinically suspected intraabdominal abscess presents a formidable challenge to the radiologist. Diagnosis by plain film or contrast studies of the bowel or genitourinary tract depends on the demonstration of a mass effect or the identification of extraluminal air.[1, 2] Angiography, which is only rarely useful, is not desirable because it represents an invasive procedure. Radionuclide liver-spleen scans are most useful with subphrenic, splenic and hepatic abscesses and are insensitive to processes outside these areas.[1, 3] These studies represent the conventional radiographic modalities but their results are often nonspecific or misleading, and even when indicative of abscess, additional confirmatory evidence is often required before treatment can be initiated.[2]

The limitations of conventional study methods have emphasized the need for a study that is reliable, fast, accurate, inexpensive and noninvasive.[4] The newer imaging methods of gallium scintigraphy, ultrasound and computed tomography (CT) meet many of these requirements. These methods demonstrate abscesses earlier than conventional studies, and with greater accuracy, leading to improved results of treatment.[5, 6]

This article emphasizes the role of ultrasound in the evaluation of suspected intraabdominal abscess. Typical ultrasound findings will be demonstrated, and the advantages of this modality over the other forms of imaging will be explained. It should be emphasized that the proper role of each new imaging method in the various clinical conditions has not yet met with general agreement.[1, 7] The studies often appear to be complementary or confirmatory rather than competitive. For this reason, the diagnosis frequently is based on the results of two or more of these studies.[1, 4]

The ability of ultrasound to demonstrate fluid collections is the basis for its success in the detection of abscesses. The typical sonographic appearance of a fluid collection is a round or oval-shaped mass which is relatively echo-free, has smooth, well-defined outer borders and shows good through-transmission of the sound energy (see Figures 1 and 2). In addition to the findings of a fluid collection, an abscess may contain scattered internal echoes, fluid-fluid levels or septa.[5, 8] These findings are related to the internal structural characteristics of the abscess mass. The

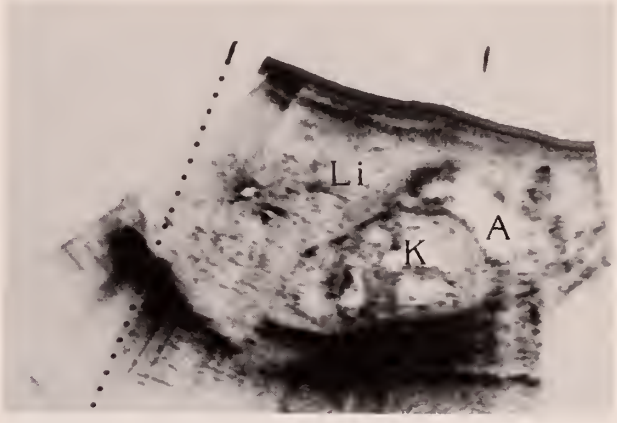


Figure 1. Longitudinal scan through right lobe of liver (Li) and right kidney (K) showing abscess (A) inferior to lower pole of kidney.



Figure 2. Transverse scan through right upper quadrant of abdomen showing abscess (A) at the anterior aspect of the right lobe of the liver. Right kidney (K); inferior vena cava (IVC).

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wall may be irregular, and there may be reactive changes in the surrounding soft tissues.[8]

Ultrasound has been shown to be a highly accurate method for evaluation of abdominal abscesses.[1, 4, 9] Its accuracy is comparable to that of computed tomography and gallium scanning. Ultrasound is not associated with ionizing radiation and is therefore without known hazard. It is generally more available than is body CT and the cost per examination is considerably lower. Time needed to complete the examination is much less than with gallium scanning. The newer high-resolution, real-time scanners permit easier and faster abdominal surveys than do the articulated-arm B-scanners or the CT scanners.[1]

While there are no known contraindications to ultrasound evaluation, there are technical limitations. One limitation is that a relatively high degree of skill is necessary to perform the examination, produce high-quality images and interpret the resulting scans. Another limiting factor is bowel gas, which effectively blocks ultrasound transmission and thus prohibits the evaluation of structures deep to the area of the gas. This is less of a problem with abscesses because they tend to displace bowel before them.[2] The presence of superficial bandages, sutures and drains prevents effective ultrasound scanning by not allowing the transducer to maintain direct contact with the surface of the abdomen. Since the ultrasound appearance of a fluid-filled structure does not define the exact nature of the fluid, clinical correlation is needed to suggest abscess rather than some other type of fluid-containing mass such as a cyst, hematoma, urinoma, lymphocele or necrotic tumor.[2, 8, 10] The accuracy of ultrasound is greatest when clinically there is localizing evidence to guide the search,[1, 7] since ultrasound utilizes a regional scanning method. Although there may be these limitations in any given case, the success rate of ultrasound is high, and it can be effectively used as the first specialized study in most cases.[1, 4, 10]

The value of gallium scanning is in its demonstration of the whole body in a single image. It is particularly useful in the chronic or subacute cases, and where no prior localizing evidence is present. Gallium scan results can often guide further local evaluation with CT and ultrasound.

An advantage of CT is that the stomach and transverse colon can be demonstrated and their relationship to the abnormal mass shown. Also, CT is not hampered by the presence of sutures, drains or other surface material.

Because each modality uses a different mechanism to produce the image and the images represent different physical properties of the object being examined, any one modality may be effective when the others are inconclusive. Recognizing that the limitations are different for each method, the clinical situation may predict which modality will be most useful in any particular case.[4] In an acute illness where a diagnosis is needed promptly, ultrasound should be the first procedure.[4] In a subacute or chronic illness, a gallium scan may be obtained first. A CT scan should be obtained only if the results of the gallium or ultrasound study are equivocal or negative in the face of contradictory clinical evidence.[4, 10]

Summary

Ultrasound can be beneficial in the diagnosis and localization of intraabdominal abscess. Its accuracy compares favorably with that of other modalities such as CT and gallium scanning. Since each has its own limitations and special advantages, more than one study is frequently needed to meet successfully this diagnostic challenge. Characteristic sonographic findings are described and illustrated. A practical approach is offered to the problem of a patient with suspected intraabdominal abscess. ★★★

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References

1. Biello, D. R., Levitt, R. G., and Melson, C. L.: The roles of Gallium-67 scintigraphy, ultrasonography, and computed tomography in the detection of abdominal abscesses. Semin. Nucl. Med. 9(1):58-65, Jan. 1979.
2. Halber, M. D., Daffner, R. H., Morgan, C. L., Trought, W. S., Thomson, W. M., Rice, R. P., and Korobkin, M.: Intraabdominal abscess: Current concepts in radiologic evaluation. AJR 133:9-13, July 1979.
3. Berger, H. J., De Graff, C., Baggish, D. A., Taylor, K. J. W. and Hoffer, P. B.: Subhepatic intraperitoneal abscess. JAMA 242:657-659, 17 Aug. 1979.
4. Korobkin, M., Callen, P. W., Filly, R. A., Hoffer, P. B., Shimshak, R. R. and Kressel, H. Y.: Comparison of computed tomography, ultrasonography, and gallium-67 scanning in the evaluation of suspected abdominal abscess. Radiology 129:89-93, Oct. 1978.
5. Bergman, A. B., Nieman, H. L., and Kraut, B.: Ultrasonographic evaluation of pericholecystic abscesses. AJR 132:201-203, Feb. 1979.
6. Silver, S., Weinstein, A. and Cooperman, A.: Changes in the pathogenesis and detection of intrahepatic abscess. Am. J. Surg. 137:608-610, May 1979.
7. Levitt, R. G., Biello, D. R., Sagel, S. S., Stanley, R. J., Aronberg, D. J., Robinson, M. L. and Siegel, B. A.: Computed tomography and ^{67}Ga citrate radionuclide imaging for evaluating suspected abdominal abscess. AJR 132:529-534, April 1979.
8. Hill, M. and Sanders, R. C.: Gray scale B scan characteristics of intra-abdominal cystic masses. JCU 6(4):217-222, 1974.
9. Taylor, K. J. W., De Graff, C., Wasson, J. F., Rosenfield, A. T. and Andirole, V. T.: Accuracy of grey-scale ultrasound diagnosis of abdominal and pelvic abscess in 220 patients. Lancet 1:83-84, 1978.
10. Duffy, P.: A surgical approach to diagnostic ultrasound and its relation to other organ imaging techniques. Aust. N. Z. J. Surg. 48(3):252-260, June 1978.

Radiologic Seminar CCX: Transhepatic Portography With Embolization of Varices

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ACUTE MASSIVE HEMORRHAGE from gastroesophageal varices often poses therapeutic dilemmas. If conservative management with intravenous vasopressin infusion and blood transfusions successfully controls the bleeding, the question of when and if to perform portal-systemic decompressive surgery arises. If hemorrhage persists in the face of adequate medical therapy, emergency surgery must be considered. Unfortunately, in patients with liver failure emergency decompressive shunt surgery or variceal ligation carries an operative mortality in the vicinity of 50 percent.[1-3]

The prohibitive risk of emergency surgery in the context of acute variceal bleeding has prompted the development of several nonoperative means of intervention. Trans-endoscopic injection of sclerosing substances directly into esophageal varices is one such approach.[4] Percutaneous transhepatic catheterization of the portal venous system with obliteration of gastroesophageal varices is another nonoperative interventional technique which is of proven value in the management of acute variceal bleeding.[5]

Case Report

A 69-year-old man was admitted to the University of Mississippi Medical Center with acute upper gastrointestinal hemorrhage. He had experienced numerous episodes of hematemesis in the past and esophagogastroscopy had shown esophageal and gastric varices. A liver biopsy had revealed Laennec's cirrhosis and alcoholic hepatitis. On admission, laboratory values included hematocrit 30, prothrombin time 12.9 sec/11.4 sec control, BUN 9 mg/dl, albumin 2.9 g/dl, alkaline phosphatase 103 U, glutamic oxalacetic transaminase 39 U, and bilirubin 1.3 mg/dl. Transendoscopic variceal sclerosis was considered, but endoscopy revealed gastric rather than esophageal varices to be the major source of hemorrhage, and these were inaccessible for puncture and injection. Blood transfusions and intravenous vasopressin were administered, but bleeding persisted.

In view of the anticipated high operative mortality, percutaneous transhepatic portal venography and variceal obliteration were attempted. The control portal venogram (see Figure 1) showed large gastric varices supplied predominately by short gastric veins. The coronary vein was small and did not appear to contribute significantly. The major supplying short gastric veins were next selectively catheterized and then occluded by the injection of small strips of surgical gelatin sponge suspended in hypertonic glucose.



Figure 1. Control transhepatic portogram shows prominent gastric varices supplied by short gastric veins (sgv). Note small coronary vein (CV), as well as splenic vein (SV), inferior mesenteric vein (IMV), proximal superior mesenteric vein (SMV) and main portal vein (PV). The spleen is enlarged.

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Figure 2. Post-embolization portogram demonstrates obliteration of supplying veins (open arrow) with non-filling of gastric varices. Occlusion extends into upper pole splenic vein branch (solid arrow).

A repeat portogram immediately post-embolization (see Figure 2) revealed obliteration of the short gastric veins and almost no filling of the gastric varices. The venous drainage from the upper pole of the spleen was also noted to be occluded, but the numerous potential collateral drainage routes made this a matter of no clinical concern. At the termination of the procedure, the catheter tract through the liver parenchyma was occluded with a gelatin sponge strip. The patient tolerated the procedure well, and has had no recurrence of bleeding to date. He is under consideration for elective portal-systemic shunting in the future.

Discussion

Although percutaneous transhepatic portal venography has been described as early as 1952, Lunderquist and Vang first reported use of the technique to obliterate gastroesophageal varices in 1974.[6]

The technique[6-8] involves passage of a teflon sheath-needle through a right mid-axillary puncture site toward the hilum of the liver. The puncture is made under fluoroscopic control with care to avoid the pleural reflection in the lateral costophrenic angle. The sheath-needle is advanced horizontally until its tip is near the right border of the T-12 vertebral body. The metal stylet is then removed and the sheath is slowly withdrawn until blood is freely aspirated. A small injection of contrast material confirms entry into a portal venous radicle and a J-tip guidewire is advanced into the splenic vein and the sheath is pushed over it. A control portal venogram is next performed to demonstrate the gastroesophageal varices and identify their feeding channels. The sheath or a curved teflon or polyethylene catheter is then manipulated into the supplying vein or veins, usually including the coronary vein.

Many different techniques have been used to obliterate gastroesophageal varices in this fashion, including injection of autologous clot[5, 8] or thrombin,[6, 9] injection of fragments of gelatin sponge,[5, 8-10] infusion of sclerosing substances such as hypertonic glucose[6] or sodium tetradecyl sulfate,[5, 8-10] occlusion with stainless-steel wire coils [11] or small balloons,[5, 8] and obliteration with tissue adhesives such as isobutyl 2-cyanoacrylate.[12, 13] Satisfactory variceal obliteration is confirmed by repeat portography. The catheter is removed after occluding the tract through the liver with a gelatin sponge strip[5, 8, 9, 12] or steel coil[11] to prevent blood or bile leakage.

The major indication for percutaneous obliteration of varices is massive variceal hemorrhage with failure to respond to conventional therapy such as vasopressin infusion in a patient who is a poor operative risk due to severe liver disease or other factors.[9] Recognized contraindications include hypersensitivity to contrast media, occlusion of the portal vein, presence of a hypervascular lesion in the needle path, and a bleeding diathesis.[7] Relative risk factors include ascites and anemia.[7]

Complications are reportedly infrequent, but have included bile leak or bleeding from the liver puncture site,[5, 7-10, 12, 13] subcapsular hematoma,[8, 12] hemothorax, [9, 13] pneumothorax, sepsis, traumatic aneurysm or laceration of an intercostal artery,[8] liver arteriovenous fistula, stray embolic particles[10] portal vein thrombosis[10, 13] and contrast-induced renal impairment.[8]

The results of transhepatic obliteration of gastroesophageal varices are difficult to compare from series to series in the literature, due to differences in time of follow-up, varying criteria for success or failure, and whether follow-up radiographic studies were performed. Overall, the procedure seems effective in the short-term, emergency control of massive variceal hemorrhage;[5, 8, 9, 11] but many patients suffer recurrent bleeding due to recanalization of obliterated varices of the opening of new feeding collaterals,[8, 11, 12] making its use questionable as elective or sole therapy.[9, 12, 23]

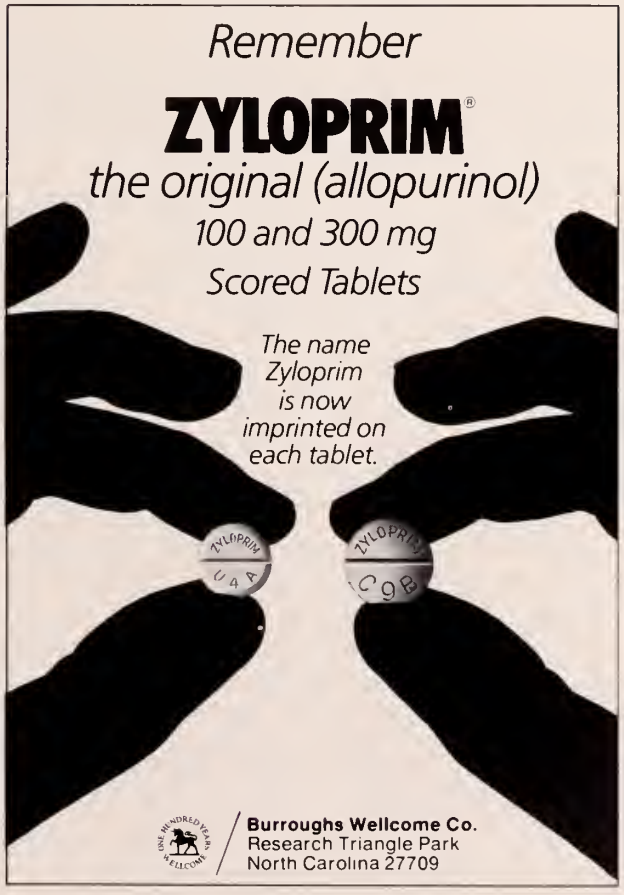
Transhepatic variceal obliteration is a feasible low-morbidity alternative to emergency surgery in the patient with acute hemorrhage and hepatic impairment. Trans-endoscopic sclerotherapy offers similar advantages, but may be impossible to perform during massive bleeding or when gastric varices are the source, as in the present case. ★★★

2500 North State Street (39216)

References

1. Malt, R. A., Abbott, W. M., Warshaw, A. L., Vander Slam T. J., and Smead, W. L.: Randomized trial of emergency mesocaval and portacaval shunts for bleeding esophageal varices. Am. J. Surg. 135:584-588, 1978.
2. Orloff, M. J., Chandler, J. G., and Charters, A. C. III, et al: Emergency portacaval shunt treatment for bleeding esophageal varices. Arch. Surg. 108:293-299, 1974.
3. George, P., Brown, C., Ridgway, G., Crofts, B., and Sherlock, S.: Emergency oesophageal transection in uncontrolled variceal haemorrhage, Br. J. Surg. 60:635-640, 1973.
4. Lewis, J., Chung, R. S., and Allison, J.: Sclerotherapy of esophageal varices. Arch. Surg. 115:476-480, 1980.
5. Widrich, W. C., Johnson, W. C., Robbins, A. H. and Nabseth, D. C.: Esophagogastric variceal hemorrhage: Its treatment by percutaneous transhepatic coronary vein occlusion. Arch. Surg. 113:1331-1338, 1978.
6. Lunderquist, A., and Vang, J.: Transhepatic catheterization and obliteration of the coronary vein in patients with portal hypertension and esophageal varices. N. Engl. J. Med. 291:646-649, 1974.
7. Viamonte, M., Jr., LePage, J., and Lunderquist, A. et al: Selective catheterization of the portal vein and its tributaries: Preliminary report. Radiology 114:457-460, 1975.
8. Pereiras, R., Viamonte, M., Jr., Russell, E., LePage, J., White, P., and Hutson, D.: New techniques for interruption of gastroesophageal venous blood flow. Radiology 124:313-323, 1977.
9. Scott, J., Dick, R., Long, R. G., and Sherlock, S.: Percutaneous transhepatic obliteration of gastro-oesophageal varices. Lancet 2:53-55, 1976.
10. Gembarowicz, R. M., Kelly J. J., O'Donnell, T. F., Jr., Millan, V. A., Deterling, R. A. and Callow, A. D.: Management of variceal hemorrhage: Results of a standardized protocol using vasopressin and transhepatic embolization. Arch. Surg. 115:1160-1164, 1980.

Journal MSMA policy limits references published to 10. For a complete bibliography, write to the author.





The President Speaking

Another Year

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

As many of us move into our twilight years, it appears that the calendar is running in double time. We all must guard against time closing in on us. Just as we must guard against time moving in on our personal lives, we must also be alert and be sure that it does not move in on our profession while we stand idly by.

I had the privilege of attending the AMA interim meeting last month in San Francisco. Again, I will say that I am impressed with the way that the AMA conducts its business. If your problem is not discussed and debated at the AMA, then I believe you really have a problem. The House of Delegates may not agree with everyone's problems (thank goodness), but they are discussed.

Why is it that more doctors do not belong to the AMA? There are only 154,150 full-pay physicians in the AMA membership. The rest of the membership comes from students, residents, and physicians exempted from dues. The main reason, I believe, that more doctors do not belong is that we have lots of freeloaders. We have those with the passive attitude of "letting George do it" and if anything goes wrong, they can say "I told you so."

Some use the excuse of the AMA not representing the practicing doctor. Well, if it does not, as I say, you do have a problem. In the past doctors have also said that they do not want to get involved with the politics of medicine or of the country. Again, I say you had better start taking an interest. (You are correct, it is going to cost you a few bucks.)

Problems which arise in medicine that we like to say are "political" usually have their origin in the state legislatures, not in Washington. We allow the non-medical, paramedical and others who think that they are doctors out-hustle us. The time has come for us to get off of it and go to work. We had better cut out one of those cruises, ski trips, or European tours and pay a little attention to our turf. There are those out there who want a piece of it. If they want it so badly, then surely medicine is worth protecting. We have said all through the years that, after all, it is the American public for which we fight. Then, let me say to you, we had better regroup and rethink our position. I believe that the recent election has given us time to do the things that we should do. Let's not carry on our fight for organized medicine in a passive way, but let's get active. As the old cliche says, let's win for organized medicine.

To those of you out there who might accidentally read this page and are not members of the MSMA and AMA, let me once more urge you to join. I do not believe you can afford not to.

The issues in medicine are big ones. We are not the friends of a lot of groups. We may not be their enemies, but everyone is looking for the best deal in town. I have been told that doctors in general are hard to deal with. They always want a discount, or a loan at low interest. If you are guilty of this, then think of the people out there who believe they are paying for more than they are getting and getting less than they deserve. Of course, *we* think medicine is the best deal in town; but, who are we to say. The customer is always right.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 1

JANUARY 1981

Incentive and Productivity—Casualties of War on Poverty

In a recent report to Congress, the National Advisory Committee on Economic Opportunity admitted that the Community Service Administration (CSA), for which it is the advisor, has not yet won the "war on poverty." Since 1964, the CSA has spent billions of dollars and millions of manhours in a liberal, welfarist, share-the-wealth policy, and now suggests that it needs to spend even more. The CSA keeps raising the "poverty level" so that now a family of four is considered "poor" if they make less than $7,450 a year. By comparison, a wage earner working 40 hours a week, 52 weeks a year, at the Federal minimum wage of $3.10 per hour makes only $6,448, or nearly 50¢ less per hour than his "poor" neighbor on welfare.

Nothing in our Constitution requires the government to support non-productive Americans. Certainly we wish to care for those who deserve and really need help, but as long as the government refuses to require able-bodied recipients to earn their benefits, the hard-working, tax-paying citizen is being penalized to support his loafing neighbor.

For those in higher income brackets, the Federal income tax is such to kill the incentive to commit money to risk investments. The Feds are giving away our tax money faster than we can make it. The carrot-before-the-donkey has become so small that it is hardly worth taking a step to get a bite.

George H. Martin, M.D.
Associate Editor
Vicksburg, MS

Medico-Legal Brief

FTC Decision Upheld

The Federal Trade Commission (FTC) order requiring the American Medical Association (AMA) to cease and desist from promulgating, implementing and enforcing restraints on advertising, solicitation, contract practices by physicians, and contractual arrangements between physicians and non-physicians was upheld (with modifications) by a three-judge panel of the Second Circuit Court of Appeals.

The AMA, the New Haven County Medical Society (NHCMS) and the Connecticut State Medical Association (CSMS) petitioned the federal appellate court to review an FTC order based upon charges that ethical standards issued by the AMA violated Section 5 of the Federal Trade Commission Act. The initial complaint based upon these charges was filed against the AMA, CSMS and NHCMS on December 19, 1975. Hearings regarding the alleged violations of the FTC Act were subsequently held from September 7, 1977 until May 5, 1978 before an administrative law judge. The administrative law judge's decision upholding the FTC's charges was appealed to the full Commission, which affirmed the judge's decision, with modifications.

On appeal before the federal appellate court, two preliminary issues were raised by the AMA: (1) that the FTC lacked jurisdiction over the AMA, and (2) that the FTC chairman should have been disqualified because he had demonstrated through his public statements that he had prejudged the key issues in the proceedings. The court found that record evidence sustained the FTC's jurisdiction and that the chairman's statements, considered in their entirety, were not grounds for disqualification.

Next, the AMA contended that its ethical guidelines were intended to be merely voluntary. However, the court framed the issue as being "whether these groups have acted in concert to effectuate restraints on advertising and solicitation in violation of the Federal Trade Commission Act." Citing the record as the basis for its conclusion, the court found that the AMA intended and expected local medical societies to impose limitations on advertising and solicitation.

Having determined that AMA engaged in the alleged concerted activity in violation of the FTC Act, the court then examined the post-complaint activities of the AMA. The AMA contended that the 1977 revisions of the Judicial Council's *Opinions and Reports* and the 1980 version of the "Principles of Medical Ethics" obviated the need to enter the FTC order. The court rejected these contentions. It

MEDICO-LEGAL BRIEF / Continued

determined that the FTC had considered the changes, but had concluded that a cease and desist order was warranted. Also rejected were claims that the cease and desist order constituted a prior restraint upon speech and impermissibly interfered with freedom of association under the First Amendment.

Assertions by the AMA that portions of the FTC order were overbroad and vague resulted in two modifications of the order. One, the order was modified to permit the AMA to enforce reasonable ethical guidelines that AMA "reasonably believes" would be concerned with false or deceptive representations. Second, limitations on advice on the ethical propriety of consideration offered or provided in return for professional services was modified to apply to "any contract with any entity that offers physicians' services to the public" and to exclude professional peer review of fee practices of physicians.

The dissenting opinion of the three judge panel focused upon the "steps promptly taken by the American Medical Association to modify and update its ethical standards after the Supreme Court's decision in *Goldfarb v. Virginia State Bar* . . . revisions that were commenced prior to the FTC's initiation of the present proceeding."

"In my view the FTC is engaged in the futile business of beating a dead horse," the dissenting judge stated. — *American Medical Association v. Federal Trade Commission*, Dkt. Nos. 79-4214, 79-4226 (C.A.2, Oct. 7, 1980)

Changes Expected For Health Programs

Since November the most-used word in the nation's capital has been "transition." To the purist, the word "interregnum" may be preferable to "transition" in describing the Washington scene — for indeed there is an interval between two successive reigns, a suspension of administrative function.

President-elect Reagan said he wants his administration to "hit the ground running" when it takes office January 20.

In a move to lay the groundwork for early action, Reagan appointed six people to review the federal structure with an eye to lower level appointments and possible reorganizations. Elizabeth Dole, wife of Senator Robert Dole (R-Kans.) and former member

(Continued on page 14)

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Branchitis and pneumonio caused by *S. pneumaniae* (farmerly *D. pneumoniae*)
Otitis media caused by *S. pneumaniae* (farmerly *D. pneumaniae*) and *H. influenzae*
Acute exacerbation of chranic bronchitis caused by *H. influenzae**
*Thaugh clinical impravement has been shown, bacteriologic cures cannat be expected in all patients with chronic respiratary disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Graup A beta-hemalytic streptacacci and staphylococci, nonpenicillinase praducers.
URINARY TRACT INFECTIONS caused by *E. cali* and *P. mirabilis*. (This drug should not be used in any *E. cali* and *P. mirabilis* infectians ather than urinary tract.)
NOTE: Perfarm cultures and susceptibility tests initially and during treatment to manitor effectiveness af therapy and susceptibility af bacteria. Therapy may be instituted prior to results of sensitivity testing.
Contraindicotions Cantraindicated in individuals with histary af an allergic reactian ta penicillins.
Warnings Cyclacillin should only be prescribed for the indicotions listed herein.
Cyclocillin has less in vitro activity than other drugs of the ampicillin class. However, clinicol trials demonstrated it is efficacious for recommended indications.
Serious and occosional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactians who experienced severe hypersensitivity reactians when treated with a cephalasporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalasporins and ather allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steraids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use af antibiatics may promote overgrowth of nonsusceptible arganisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B Reproductian studies perfarmed in mice and rats at doses up ta 10 times the human dose revealed na evidence of impaired fertility or harm ta the fetus due ta cyclacillin. There are, however, na adequate and well-cantralled studies in pregnant women. Because animal repraductian studies are not always predictive af human respanse, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is nat known whether this drug is excreted in human milk Because many drugs are, exercise cautian when cyclacillin is given ta a nursing wamon.
Adverse Reactions Oral cyclacillin is generally well talerated As with ather penicillins, untaward sensitivity reactions are likely, particularly in those who previously demanstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, ar urticaria. Adverse reactians reparted with cyclacillin: diarrhea (in appraximately 1 aut of 20 patients treated), nausea and vamiting (in approximately 1 in 50), and skin rash (in appraximately 1 in 60). Isalated instances af headache, dizziness, abdaminal poin, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may accur and are reported with ather penicillins are anemia, thrambocytopenia, thrambacytapenic purpura, leukapenia, neutropenia and eosinophilio These reactians are usually reversible an discontinuotion of therapy
As with other semisynthetic penicillins, SGOT elevations have been reparted
As with antibiotic therapy generolly, cantinue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradicatian is evidenced In Graup A beta-hemalytic streptococcol infectians, at leost 10 days* treatment is recammended to guard against risk of rheumatic fever or glomerulanephritis In chranic urinary tract infectian, frequent bacteriolagic and clinical appraisal is necessory during therapy and passibly for several manths after. Persistent infection may require treatment far several weeks.
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Chronic Infectians	500 mg q.i.d	100 mg/kg/day q i.d
Otitis Media	250 mg to 500 mg q i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q i d †	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d	100 mg/kg/day

*Dosage should nat result in a dase higher than that far adults.
†depending on severity

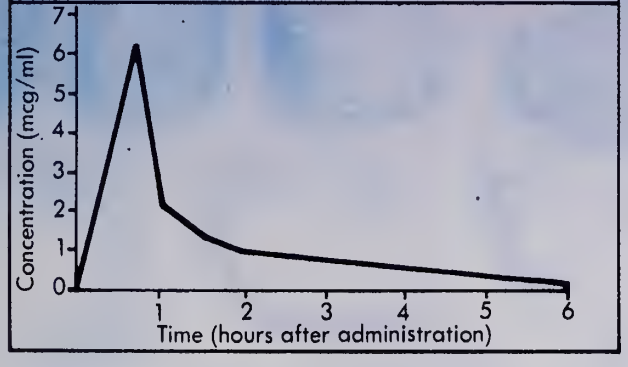
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NEW NAME

of the Federal Trade Commission, will handle human resources — including the Health and Human Services Department, the Housing and Urban Development Department and the Department of Education.

Reagan has indicated opposition to the separate Department of Education that was established to carry out a controversial campaign pledge by President Carter aimed at wooing the votes of teachers. And there has been renewed talk about reorganizing the HHS Department in order to put more emphasis on health and less on its welfare functions.

Reagan's health advisory group, headed by William Walsh, M.D., president of Project Hope, has proposed a pool arrangement for private health insurance companies under which insurance would be made available to people whose disabilities make them uninsurable at present.

They would pay premiums which would be subsidized, if necessary, by the rest of the insured population.

Other recommendations included:

— Allowing Medicare-Medicaid beneficiaries to choose private coverage with premiums paid by the government.
— Examining the $1 billion renal dialysis program to determine if services could be provided at less cost.
— Expanding home health benefits with an aim to reducing Medicare-Medicaid payments for hospital and nursing home care.
— Decentralizing health planning.

The thrust of the report toward easing federal regulation and encouraging a greater role for the private sector was mirrored in a report on health policies issued by the Heritage Foundation, a Washington, DC, study group.

The Heritage Foundation, a conservative think tank with strong ties to the Reagan administration, has come up with a blueprint for future government that includes some sweeping changes in health.

The Foundation calls for examination of methods of "phasing out Medicaid and Medicare in their present forms, pursuant to the development of systems relying on 'vouchers' and a more competitive private market."

Foundation President Edwin Feulner said the Foundation's "Mandate for Leadership" study, a year in the making, is a basic set of conservative policy recommendations "which I hope the Reagan administration will give its careful and serious consideration." He said the study represents the collected opinions of more than 250 experts from government, universities, think tanks, and the business and legal professions.

The author of the report on the HHS Department was David Winston, an aide to Sen. Richard Schweiker (R-Pa.).

The HHS section proposed a freeze on all HHS consulting contracts pending a full review of their usefulness, noting that the department "is very heavily dependent on such outside consultants."

It called for concentration on the role of HHS as a "'last resort,' while deregulating and enhancing the private sector's innovative capabilities."

Turning to the Health Care Financing Administration (HCFA), which runs Medicare and Medicaid, the report said HCFA has considerable difficulties managing fiscal intermediaries (e.g. insurance carriers) through which Medicare and Medicaid programs are administered. Furthermore, it finds it difficult to restrict health cost increases because of the retrospective, cost-based reimbursement system for these programs.

Immediate examination of means to improve the administration of Medicaid and Medicare was urged. Containment policy should be turned away from a controls and guidelines approach to a process of reimbursement reform, deregulation, and improved competition, according to the study.

A significant recommendation was that "attention should be given, however, to the reduction or elimination of the Professional Standards Review (PSRO) program."

The Foundation study also noted that the National Institutes of Health have been criticized for duplicating work in the private sector. "Private organizations should be encouraged to carry out more development work, reserving NIH for areas with little commercial promise. Methods could be examined of altering the tax treatment of private research to encourage private involvement in more risky, innovative fields."

The report added that "bureaucratic problems of NIH might be reduced by strengthening the Director's authority to improve budgeting and planning, and by analyzing the cost structure with a view to reducing indirect costs." Another significant proposal was for a thorough review of federal involvement with Health Maintenance Organizations (HMOs) with a possible six-month moratorium on all new program awards and extensions.

MEDICAL ORGANIZATION

Central Medical Society Supports Hospitality Center



Central Medical Society contributed $3,000 to the Jackson Hospital Hospitality Center, which provides meals and lodging for relatives of out-of-town patients hospitalized in Jackson. Dr. Fred McMillan, society president, presented the check to Mrs. Barbara Barnes, executive director of the Jackson YWCA. The Center is located at the State Street YWCA. Since its opening in May 1980, the Center has provided 3,034 "guest nights" for people from all over Mississippi, many other states, and three foreign countries. The service has been provided for patients in seven Jackson area hospitals: St. Dominic's Hospital, VA Medical Center, Methodist Rehabilitation Center, University Medical Center, Hinds General Hospital, Mississippi Baptist Medical Center, and Rankin General Hospital.

Dr. Curtis Caine Elected President of AAPS

Curtis W. Caine, M.D., of Jackson assumed the presidency of the Association of American Physicians and Surgeons at the organization's recent annual meeting in Louisville, IN.



The AAPS is an advocate of the practice of private medicine, believing in sharply limited powers of the federal government. Previously Dr. Caine served as secretary, speaker of the House of Delegates, delegate, and director of the organization, and served as chairman of numerous committees.

Dr. Caine was born in New Orleans. He received his undergraduate and medical degrees from Tulane University, and has practiced in Jackson since 1948. He is a member of numerous professional organizations, and is an instructor in anesthesiology at the University of Mississippi Medical Center.

In 1979 Dr. Caine received the Airman of the Year Award from the 2500-member Flying Physicians Association, a society which promotes aviation proficiency, safety, and Samaritan activities.

PRACTICE MANAGEMENT MAILBOX

Patient Information Brochure Can Improve Relationship

Quite often, patients spend time in a physician's waiting room prior to seeing the doctor. During this time, the physician has an excellent opportunity to get the doctor-patient relationship off to a good start before he even sees the patient. The physician can avail himself of this opportunity by the use of a patient information brochure.

A patient information brochure should be designed to do exactly what its name implies — that is, inform the patient. It should have an introductory paragraph which tells the patient that the brochure has been designed with the patient in mind to answer some of the questions the patient might have con-

cerning the practice.

Secondly, the brochure should contain a biographical sketch of the physician(s) in the office. This biographical sketch should not be limited to educational background but should also contain the names of spouse and children, church affiliation, civic clubs or organizations, and even hobbies. This type of information conveys the idea to the patient that the physician is human too, and may create the opportunity for a minute or two of light conversation in the examining room which can have a very positive effect toward easing anxieties that the patient might have, especially on the first visit.

Another portion of the brochure should be used to familiarize the patient with the type of practice of the physician. It should explain in layman's language the particular ailments or conditions the physician treats.

The brochure should also have information relative to office hours, appointment scheduling, and a phone number for after-hours emergencies. In addition to these items, the brochure should contain the office policy on payment for services. For example, if payment is expected at the time of service, the brochure should so state. If bank cards are accepted or charges are billed on a monthly basis, the patient should be so advised in the brochure.

The closing remarks in the brochure should encourage the patient to feel free to ask questions. By utilizing a patient information brochure, the practicing physician can answer many questions in advance, familiarize the patient with the doctor and his office procedures, and most importantly, create a good doctor-patient relationship that should be beneficial to both parties. — B.C.M.

NEW MEMBERS

Anderson, William E., III, Greenwood. Born Davenport, IA, May 11, 1949; M.D., University of Tennessee School of Medicine, Memphis, 1974; interned Baptist Memorial Hospital, Memphis, TN, one year; surgery residency, same, 1975-76; orthopedic surgery residency, University of Tennessee and Campbell Clinic, Memphis, 1977-79; elected by Delta Medical Society.

Ashford, William Clay, Jackson. Born Lambert, MS, June 27, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, one year; medicine residency, same, 1976-77; ophthalmology residency, same, 1977-80; fellowship Baylor College of Medicine, Houston, March-July 1980; elected by Central Medical Society.

Barkley, Thomas Ford, New Albany. Born New Albany, MS, July 5, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and medicine residency, University Medical Center, Jackson, 1977-80; elected by Northeast Mississippi Medical Society.

Bass, Edward J., Meridian. Born Columbia, MS, Nov. 7, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and medicine residency, University Medical Center, Jackson, 1976-79; elected by East Mississippi Medical Society.

Cox, John Warren, Tupelo. Born Phoenix, AZ, Apr. 7, 1949; M.D., Ohio State University College of Medicine, Columbus, 1974; interned and nephrology residency, Iowa University, Iowa City, 1974-76; nephrology residency, Ohio State, Columbus, 1976-77; elected by Northeast Mississippi Medical Society.

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Cutrer, Roderick Tate, Petal. Born Magnolia, MS, June 1, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and family practice residency, University Medical Center, Jackson, 1976-79; elected by South Mississippi Medical Society.

Egger, John Fontaine, Jr., Jackson. Born Selma, AL, Jan. 4, 1929; M.D., Tulane University School of Medicine, New Orleans, 1953; interned and surgery residency, Charity Hospital, New Orleans, 1953-60; colon and rectal surgery residency, Ochsner Foundation Hospital, New Orleans, 1960-61; elected by Central Medical Society.

Garrison, Norman A., Corinth. Born Corinth, MS, Jan. 8, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned University Medical Center, Jackson, one year; elected by Northeast Mississippi Medical Society.

Harris, John Stephen, Meridian. Born Jonesboro, AR, Oct. 21, 1947; M.D., University of Tennessee College of Medicine, Memphis, 1972; interned and ob-gyn residency, National Naval Medical Center, Bethesda, MD, 1972-77; elected by East Mississippi Medical Society.

Holleman, Jeremiah H., Jr., Columbus. Born Ft. Benning, GA, July 26, 1946; M.D., Tulane University School of Medicine, New Orleans, 1971; interned and general surgery residency, University Medical Center, Jackson, 1971-76; fellowship peripheral vascular surgery, 1978-79; elected by Prairie Medical Society.

Martin, Thomas S., Hattiesburg. Born Lafayette, AL, Sept. 25, 1930; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned Baptist Hospital, Jackson, 1963-64; elected by South Mississippi Medical Society.

McNair, Alfred Earl, Jr., Pascagoula. Born Pascagoula, MS, Feb. 23, 1952; M.D., Columbia University College of Physicians and Surgeons, New York, NY, 1975; interned and medicine residency, Columbia Presbyterian Medical Center, New York, 1975-78; fellowship gastroenterology, Stanford University Medical Center, Palo Alto, CA, 1978-80; elected by Singing River Medical Society.

Moore, Paul Harold, Jr., Pascagoula. Born Louisville, MS, Aug. 22, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and radiology residency, University of New Mexico, Albuquerque, NM, 1976-80; elected by Singing River Medical Society.

Moore, Thomas Saunders, Jackson. Born Newport News, VA, Oct. 8, 1945; M.D., Cornell University Medical College, New York, 1971; interned and radiology residency, Georgetown University Hospital, Washington, DC, 1971-73; radiology residency, University of Virginia, Charlottesville, 1975-78; radiology fellowship, same, 1978-79; elected by Central Medical Society.

Person, Brett T., Greenwood. Born Greenwood, MS, March 7, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and medicine residency, University Medical Center, Jackson, 1977-80; elected by Delta Medical Society.

Pharr, Richard Warren, Brandon. Born Oxford, MS, Dec. 16, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and ophthalmology residency, Baptist Memorial Hospital, Memphis, TN, 1976-80; elected by Central Medical Society.

Reid, William F., Meridian. Born Pasquotank County, NC, Oct. 23, 1948; M.D., Tulane University School of Medicine, New Orleans, 1975; interned, medicine residency and pulmonary fellowship, Ochsner Clinic, New Orleans, 1975-80; elected by East Mississippi Medical Society.

Sampson, Charles E., Jr., Jackson. Born Greenwood, MS, March 7, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned and ob-gyn residency, University Medical Center, Jackson, 1963-67; gynecology-oncology fellowship, M. D. Anderson Hospital, Houston, TX, 1969-70; elected by Central Medical Society.

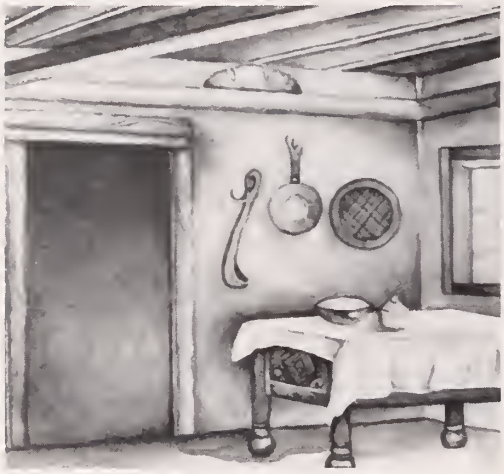
Turnage, John Neil, Aberdeen. Born New Hebron, MS, May 17, 1926; M.D., University of Tennessee College of Medicine, Memphis, 1956; interned Methodist Hospital, Memphis, 1957; elected by Northeast Mississippi Medical Society.

Turner, Harry L., Jr., Waynesboro. Born Hattiesburg, MS, March 13, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and diagnostic radiology residency, University Medical Center, Jackson, 1976-80; elected by South Mississippi Medical Society.

Weddle, Richard E., Tupelo. Born Memphis, TN, June 17, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and neurology residency, University Medical Center, Jackson, 1974-78; elected by Northeast Mississippi Medical Society.

Yesterday's Folk Remedy:

A rye loaf in the rafters.



Early in this century in Central Europe, almost every farm family kept a loaf of moldy rye bread on one of the kitchen beams. When any family member was cut or bruised, it was an old custom to cut a thin slice from the outside of the loaf, mix it into a paste with water, and apply it to the wound with a bandage. It was believed that no infection would then result from the cut.[1]



Today's Tradition:

Tegopen®

(cloxacillin sodium)

for the treatment* of known or suspected staphylococcal infections such as:

- Acute sinusitis
- Furunculosis and carbuncles
- Impetigo
- Secondarily infected dermatitis
- Cellulitis
- Abscesses
- Infected sebaceous cysts

In serious, deep-seated staph infections, 500 mg q.i.d. dosage is recommended.†

- Tegopen has been reported active against 96% of *Staphylococcus aureus*.[2]
- 80% of *S aureus* has been reported resistant to amoxicillin and ampicillin.‡[2]
- 88% of *S aureus* has been reported resistant to penicillins G and V.‡[2]
- Staph resistance to erythromycin may develop during a course of therapy.[3]



Available as 500-mg and 250-mg capsules and Oral Solution 125 mg/5 ml.

Tegopen® (cloxacillin sodium) Today's Penicillin for Today's Physician

1. Florey HW, Chain E, Heatley NG, et al: *Antibiotics*. London, Oxford University Press, 1949, p 2.
2. Bac-Data Bacteriologic Report, Professional Market Research, 1978-1979. The clinical significance of *in vitro* data is unknown.
3. Erythromycin prescribing information (in *Physicians' Desk Reference*, ed 34. Oradell, NJ, Medical Economics Co, 1980) states that staph resistance may develop during treatment.

See brief summary of prescribing information on an adjoining page.

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*Note: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin

†In serious, life-threatening infections, oral preparations of the penicillinase-resistant penicillins should not be relied on for initial therapy.

‡Not all isolates may have been tested using both discs.

Tegopen®
(cloxacillin sodium)
Capsules and Oral Solution

Brief Summary of Prescribing Information
For complete information, consult Official Package Circular
(12) 9/11/75

INDICATIONS
Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)
Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE
When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.
Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.
Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.
Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:
A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.
There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.
Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.
As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q 6h.
Children: 50 mg./Kg./day in equally divided doses q 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.
N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

NEW MEMBERS / Continued

WHITTINGTON, CURTIS D., Jackson. Born Natchez, MS, Dec. 17, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and ophthalmology residency, University Medical Center, Jackson, 1975-80; elected by Central Medical Society.

WILLIAMSON, JOHNNIE WARREN, Tupelo. Born Moss Point, MS, Sept. 11, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned, general surgery, peripheral vascular fellowship, University Medical Center, Jackson, 1974-80; elected by Northeast Mississippi Medical Society.

PERSONALS

G. WILLIAM BATES of UMC presented a paper at the recent Southern Gynecologic Society meeting in San Antonio, TX.

C. DUANE BURGESS of Hattiesburg was named a fellow of the Academy of Psychosomatic Medicine at the academy's annual meeting in Bal Harbor, FL.

MICHAEL H. CARTER of Greenwood was inducted into the American College of Surgeons during the ACS annual meeting in Atlanta.

WILFRED Q. COLE of Jackson has been appointed Jackson regional coordinator for the "National Crusade Against Asthma," sponsored by the Asthma Care Association of America.

A. W. CONERLY of UMC was guest speaker at recent meetings at the Golden Triangle Regional Medical Center in Columbus and at the Holmes County Hospital in Lexington.

JOHN GOUDELOCK of New Albany has been named a fellow of the American College of Surgeons.

WALTER D. GUNN of Quitman has been named a fellow of the American Academy of Family Physicians.

JAMES HARDY of UMC spoke at a joint meeting of the Louisiana Chapter of the American College of Surgeons and Surgical Association of Louisiana in New Orleans; was the Alvred Strauss Visiting Professor at the Abraham Lincoln School of Medicine in

Chicago, and gave the J. C. Thoroughman Lecture at Emory University in Atlanta.

John F. Hassell of Laurel has been named a fellow of the American Academy of Family Physicians.

Thomas Herrin of UMC has been appointed to the Subcommittee on Emergency Cardiac Care of the American Heart Association.

John Jackson of UMC spoke at a medical staff meeting at Northwest Mississippi Regional Medical Center in Clarksdale.

Herbert Langford of UMC spoke at a hypertension workshop for the Tennessee Academy of Family Practice in Gatlinburg; at the V.A. Hospital in Philadelphia, PA; at Riverside Hospital in Newport News, VA; and at a meeting of the American Clinical and Climatological Association in Williamsburg, VA.

Robert Marascalco of Vicksburg has been elected to fellowship in the American Academy of Orthopaedic Surgeons.

John Morrison of UMC was program director for the recent National Perinatal Association meeting in Atlanta.

Binford T. Nash of Starkville has been named a fellow of the American Academy of Family Physicians.

Somprasong Songcharoen of Jackson announces the association of Douglas E. Gorman for the practice of plastic and cosmetic surgery.

John C. Stepan of Vicksburg has been elected president of the Mississippi Ultrasound Society.

J. S. Weatherall has associated with W. J. Patterson at the Clinton Family Clinic, 501 Springridge Road, in Clinton.

Carl C. Welch of Corinth was speaker at a recent symposium on "New Career Opportunities in Health, Economics and Energy."

William Boyce White of Laurel has been recertified as a diplomate of the American Board of Family Practice.

Chris E. Wiggins announces the relocation of his office for the practice of orthopedic surgery to 2202 Old Mobile Highway in Pascagoula.

Winfred Wiser of UMC was visiting professor at the Medical Center of Columbus, GA, in November.

PLACEMENT SERVICE

General Practitioner or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

Associate or Physicians interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

Surgeon to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

General Practice opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821.

Situations Wanted

Board eligible anesthesiologist seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

Pediatrician desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

Pediatrician completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

General Practitioner seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

Cardiologist seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar De-Sai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

Pediatrician and Pathologist (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

Pathologist especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

Physician completing training in 1981 seeks general practice location, preferably in shortage area. Contact Kenneth K. Wheatley, Jr., M.D., 1800 Holcombe Boulevard, Apt. 205, Houston, TX 77030.

Pediatrician desires clinic or ER location in south Mississippi. Presently in training; available January 1981. Contact S. G. Eggen, M.D., 4929 Cleveland Place, Metairie, LA 70003 or call 504/837-3000 (ext. 2436 or 2395).

Pediatrician seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

Family Practitioner seeks practice location in Mississippi. Graduate of University of Washington School of Medicine, 1950. Presently practicing in Alaska. Contact Donald F. McKay, Box 631, Haines, AK 99827.

Pathologist — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CLASSIFIED

Two primary care physicians and nurse practitioner needed for two primary health care clinics in rural Itawamba County, MS, operated under a DHHS-PHS Rural Health Initiative grant: (1) fully-renovated, newly equipped clinic and (2) new clinic to be built with FmHA/Rural Health Care program funds in late 1980. Program now provides full-time dental services. Service area approximately 18,750; full-time administrator and social worker. Salary negotiable. Prospects for financial self-sufficiency excellent. Contact: The Urgent Rural Needs, Inc. (TURN); P.O. Box 617, Fulton, MS 38843. Telephone (601) 585-3884.

Established Jackson Physician has office space for lease; ophthalmologist preferred; share waiting room. Contact: Lynn D. Abernethy, M.D., 653 North State St., Jackson, MS 39201; (601) 354-5385.

Equipment for Sale. Burdick EKG; Clay Adams Hematocrit centrifuge. Contact Dr. L. T. Carl, Jackson, MS, 366-8494 (office) or 366-3710 (home).

Family practice physician: To work in Primary Care Clinic funded by DHHS. Located in Health Department serving population of over 350,000 in Mobile County, AL. Must be an M.D., eligible for licensure in Alabama. Prefer Board Eligibility or Board Certification in Family Practice or Internal Medicine. Up to $39,312 per year to start depending on qualifications. Call Pete Miller collect (205) 690-8104. EOE/M/F/H.

Locum Tenens — COMPHEALTH. Our medical group can place a well-qualified physician in your practice during your absence. For more information call or write: Comprehensive Health Systems, Inc. 175 West Second South, Salt Lake City, UT 84101; (801) 532-1200.

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PHYSICIANS

One of America's largest health care corporations is currently seeking a full and part-time Physician for our Plasma Donor Center located in Mississippi. Responsibilities will include performing physicals in conjunction with donor screening and evaluation. The part-time position would provide support when regular staff Physicians are on vacation.

Our requirements are flexible and we will consider licensed but non-practicing Physicians as well as those desiring to work on a consulting basis.

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IN CONCLUSION

From the New York State Society of Internal Medicine News, these thoughts by Dr. Norman S. Blackman, editor: "Doctors Ought to Care ... that our patients are being convinced that we don't care ... that government is pre-empting individual professional judgments for individuals by individual physicians for the expediency of adapting big government to mass medical care ... about participating actively in the non-remunerative aspects of medical practice such as community affairs, teaching, organized medical activities, etc...Doctors Ought to Care that many of us do not care enough!"

From the West Virginia Medical Journal, an answer to the charge that minority views can find no expression in medical affairs: "Those who seriously hold such an opinion reveal one very damning fact about themselves: they have never been to a county medical society meeting, let alone a state association or a national AMA meeting...Minority views are undeniably, sometimes relentlessly and always vigorously expressed...Medical meetings, in truth, are the epitome of democracy. All who attend can and sometimes, it seems, do make speeches on any subject. No one could possibly go away with the feeling that he has been muzzled."

From the Pennsylvania Medical Journal, these thoughts on cost of government regulations and the continuing reports of "savings" by regulatory agencies: "The inconvenience of the physician, hospital administrator, registered nurse, allied health professionals, and especially the patients, both in time and dollars, seem never to be figured in the savings...Legislation was intended to aid and protect society but instead, it has grown into a tangle of overlapping and conflicting rules. The tangle snares too many people, and the worst part is, we pay dearly for the privilege of being caught."

From the Wisconsin Medical Journal, a proposal to extend the federal quest for "truth in labeling" with one more bureaucrat - the national legislation semanticist: "His job would be to take the extraneous, hopeful, beguiling, endearing adjectives out of our legislative bills. He would also require bills to state more correctly what they will eventually accomplish. This would result in...the Petroleum Excise Tax, National Sickness Indemnity Act, the Welfare Redistribution Act, etc. These bills may then avoid criticism from the folks in charge of monitoring deceptive labeling but may not be able to pass muster for their efficacy."

Best Wishes for a Happy New Year

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BALCONY



February 1981

Journal of the State Medical Association

Mississippi

(ISSN 0026-6396)

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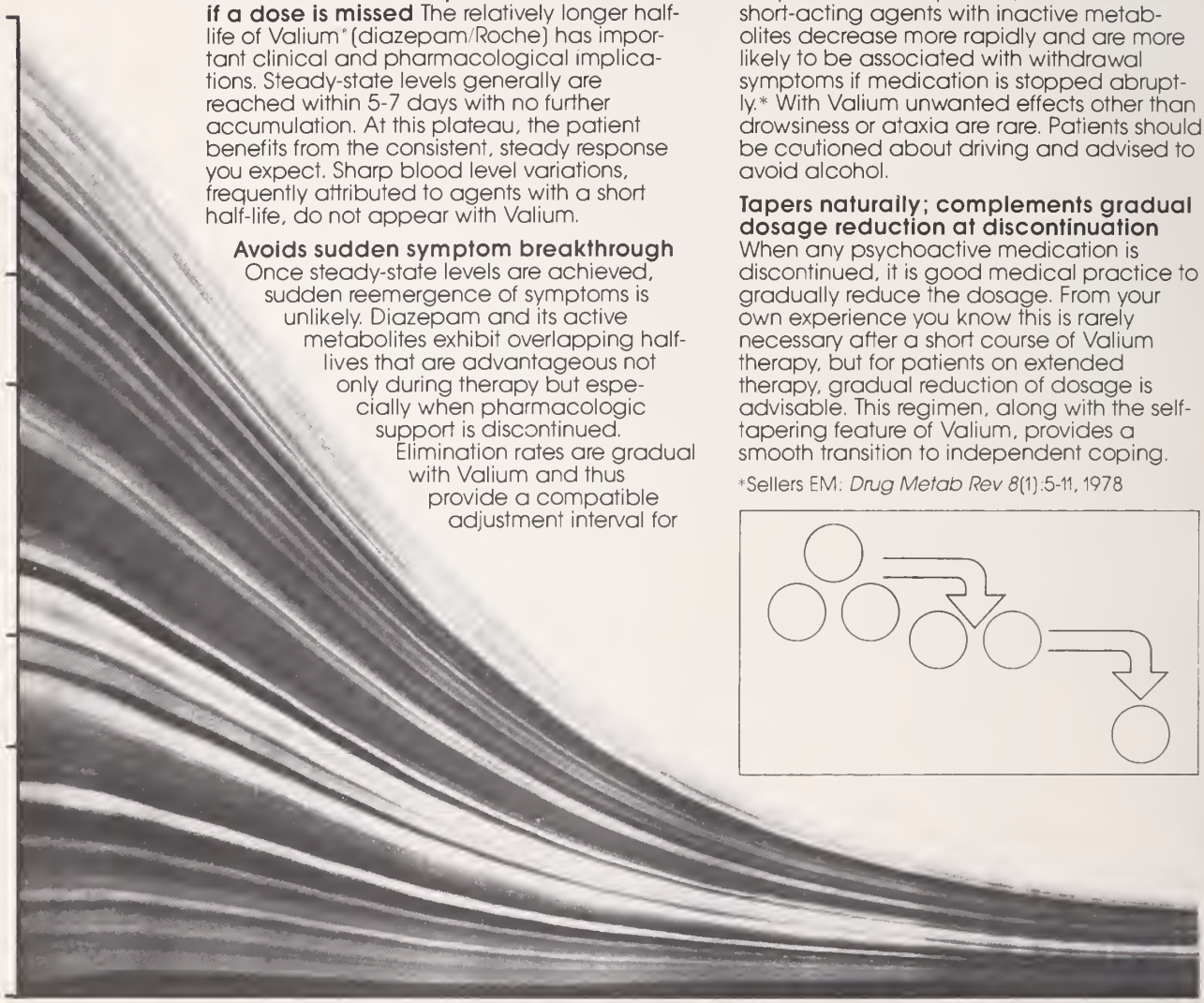
Ultrastructure of an Undifferentiated Neoplasm

Acquired Tracheo-Esophageal Fistula Resulting from Blunt Trauma

CT in Tail of Pancreas Pseudotumor Evaluation

half-life

Just one built-in advantage



Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978

in the management of symptoms of anxiety

Valium®(IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

Before prescribing, please see summary of product information on next page

ROCHE®

Valium® IV
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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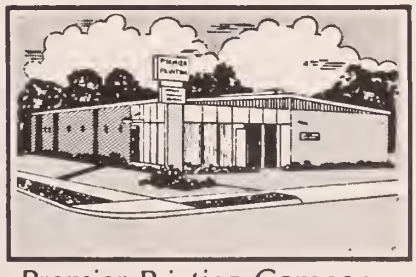
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JOURNAL of the MISSISSIPPI State Medical Association

February 1981, Volume XXII, Number 2

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(ISSN 0026-6396)



Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX®

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS (mebendazole)

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Committed to research...
because so much remains to be done.

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JPI-023



Broad-spectrum coverage in mixed helminthic infections

TABLETS
Vermox®
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

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UMC Schedules Neurology Symposium

The University of Mississippi Medical Center's third annual Neurology Spring Symposium in Jackson March 26-27 will emphasize neurological infections.

All sessions will be at the Jackson Holiday Inn Medical Center. The symposium is designed for the neurologist, neurosurgeon, internist, pediatrician and family practitioner.

The seminar will include diagnosis and treatment of chronic meningitis, infectious myositis and neuropathy, recent advances in treatment of vascular headache, advances in neonatal and childhood neurological infections and advancement in the treatment of Parkinson's Disease.

Symposium coordinator is Dr. Shri K. Mishra, UMC associate professor of neurology and chief of the neurology service at the Veterans Administration Medical Center.

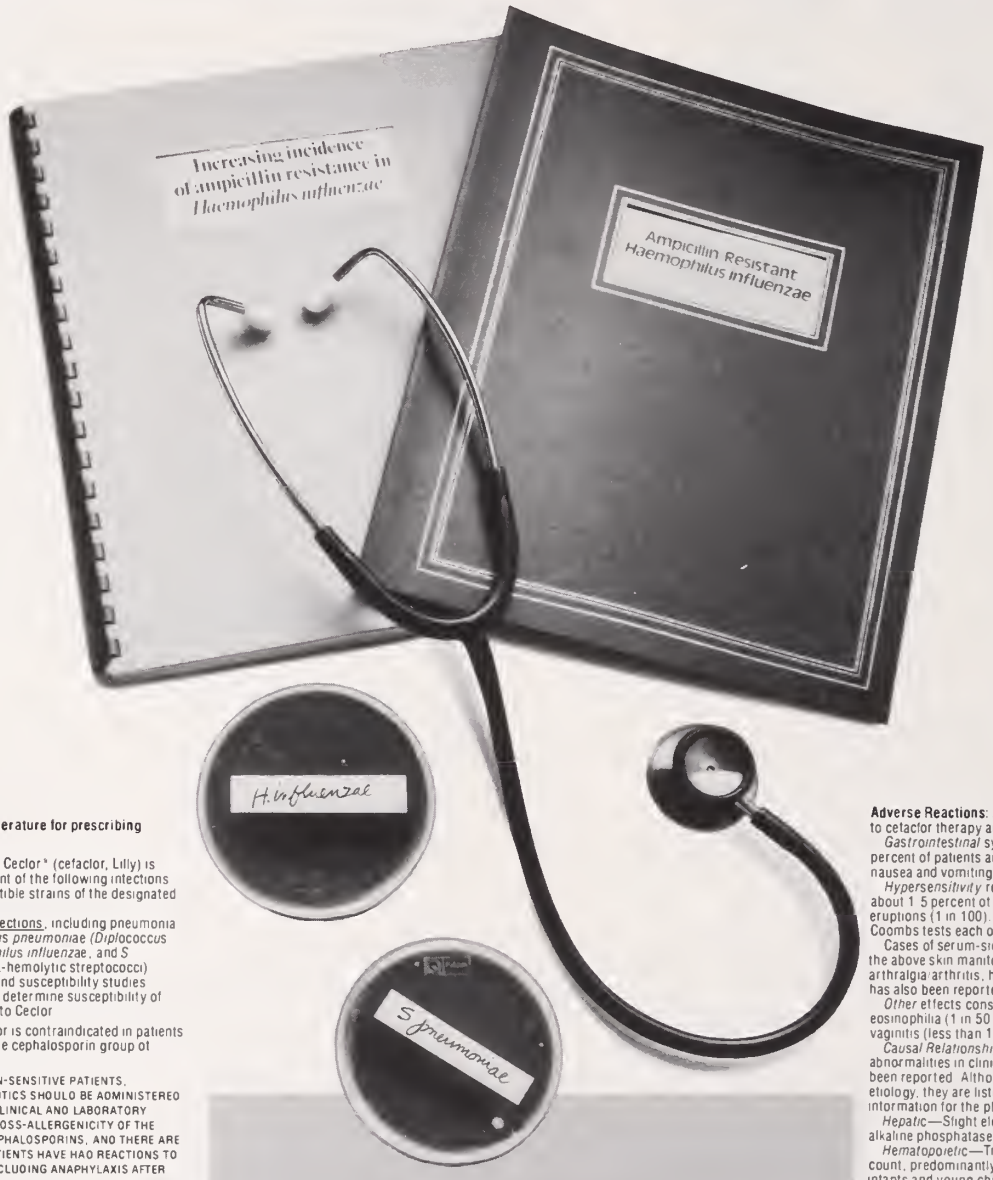
Guest faculty are Dr. John E. Bennett, chief of the clinical Mycology Section, Laboratory of Clinical Investigation, National Institute of Allergy and Infectious Diseases; Dr. Donald B. Calne, clinical director, National Institute of Neurological and Communicative Disorders and Stroke, National Institutes of Health; Dr. Kenneth P. Johnson, chief of neurology research at the Veterans Administration Medical Center, in San Francisco and professor of neurology and pathology, the University of California-San Francisco; and Dr. Jay P. Sanford, dean of the School of Medicine, Uniformed Services University of Health Sciences.

Sponsors are the UMC School of Medicine Department of Neurology and Medicine, the Veterans Administration Medical Center Neurology Service and Medicine Service and the Medical Center Division of Continuing Health Professional Education. Partial support is provided by the Jack A. Stokes Memorial Fund, Class of 1960 and the General Continuing Medical Education Fund of the Medical Alumni Chapter, University of Mississippi Alumni Association.

Course fee is $150. Advance registration is required. The symposium carries 13.7 hours credit in Category I of the Physician's Recognition Award of the American Medical Association and the American Academy of Family Physicians.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4912.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGDT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae*.[8]

Note Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information.

References

1 Antimicrob Agents Chemother , *8* 91, 1975
2 Antimicrob Agents Chemother , *11* 470, 1977
3 Antimicrob Agents Chemother , *13* 584, 1978
4 Antimicrob Agents Chemother , *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R. Luthy), II: 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother , *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Lilly

Eli Lilly Industries, Inc.
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100061

NEWSLETTER

February 1981

Dear Doctor:

Regulation is out and competition is in as far as health care is concerned, says the editor of The Internist. In an article entitled "Competition Comes of Age" he explores Americans' motivations in making decisions regarding their health care. In another article, Duke University Professor Clark C. Havighurst, former FTC consultant and author on health care regulation, observes that one cannot predict reliably what changes competition will bring about.

> Havighurst suggests that employers, unions and physicians could help consumers choose an appropriate health plan and remarked that regulators are "ignorant and irrational when trying to decide what consumers want." Other writers note that competition is not new to American health care, but its effects on cost and quality of care are still unknown.

Physicians are urged to complete the AMA's Census of Physicians' Professional Activities (PPA) questionnaire. Information will go into the 28th edition of the American Medical Directory and the Physician Masterfile. Established in 1906, the Masterfile is a source of data for medical professional organizations, universities and medical schools, research institutions, government agencies, etc.

Long-term pain relief in women who receive coronary bypass surgery is not as good as that in men, an Emory University study shows. Seventy percent of the males surveyed at late followup were without angina pain symptoms, while only 52 percent of the women were pain-free. Although total pain relief was not as good, over 90 percent of the women were significantly improved, the report stated.

Artificial sweeteners probably will figure in the news in 1981. The 97th Congress is expected to deal with the expiring moratorium against the ban of saccharin. Last fall the FDA denied an appeal by Abbott Laboratories for reapproval of cyclamate and heard recommendations against the approval of aspartame. Action seeking approval of the sweeteners will likely be renewed.

Plans for MSMA's 113th Annual Session (April 26-30 in Biloxi) are nearing completion. A special highlight will be the presentation of the First Annual James Grant Thompson Memorial Lecture by Dr. Gerald Weissmann, professor of medicine at New York University School of Medicine. This month Journal MSMA begins articles on Annual Session, and the April issue will contain the complete program.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

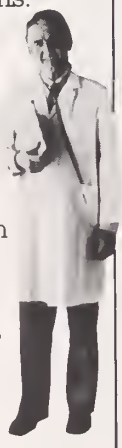
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A medical practice is communications intensive. Bell – at the forefront of communications knowledge – offers systems and services to help you make more and better use of your doctor-patient time. And increase staff productivity by increasing efficiency in office procedures.



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F-E-P CREME® • SU-TON® • TWIN-K® • TWIN-K-Cl™



For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin – Pramoxine HCl – Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (½ ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications.
See prescribing information on last page of this advertisement

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.



For Potassium Supplementation Improved Compliance...

TWIN-K®

Each 15 ml supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

The good tasting potassium supplement

- Designed for prophylactic and therapeutic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient dosage aid patient compliance.
  The organic salt of potassium can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine.[1]

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, page 1959

In Cases with Chloride Deficiency...

TWIN-K-Cl™

Each 15 ml supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride in a sorbitol and saccharin solution.

The good tasting potassium supplement with chloride

- In hypokalemic hypochloremic alkalosis, chloride ions are required. Twin-K-Cl is specially formulated to be a good tasting chloride containing potassium supplement.
- Contains no potassium chloride. Twin-K-Cl is a carefully balanced combination of organic potassium salts plus ammonium chloride.
- In hypochloremic patients, potassium should be provided as the chloride salt, or chloride ion must be made available in some other form, such as ammonium chloride or sodium chloride.[1]

See prescribing information on last page of this advertisement.



F-E-P CREME®

DESCRIPTION

F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani); folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris corporis, pedis); moniliasis; intertrigo. Final classification of the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS

Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye, tuberculosis of the skin, most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS

This product is not for ophthalmic use.

In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY

Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS

F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period.

Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests. The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine.

Prolonged use of this drug may result in an overgrowth of non-susceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS

Skin rash or hypersensitivity may occur following topical application.

The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION

Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED

F-E-P Creme ½ ounce (15 gm) tubes NDC 0524-0026-51
F-E-P Creme Plain ½ ounce (15 gm) tubes NDC 0524-0025-51

Federal law prohibits dispensing without a prescription.

July 1980

SU-TON®

DESCRIPTION

Forty-five milliliters of SU-TON contain the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	9 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE

SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS

Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS

The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS

Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS

Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE

Drug dependence has not been reported with SU-TON.

OVERDOSAGE

Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION

One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED

Bottles of 473 ml (16 fl oz) NDC 0524-0015-16

Federal law prohibits dispensing without prescription.

February 1980

TWIN-K®

DESCRIPTION

Each 15 milliliter (one tablespoonful) supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

INDICATIONS AND USAGE

For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS

Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS

TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation, it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS

Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS

Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE

The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes. Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION

The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of potassium ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED

Bottles of 1 pint (16 fl. oz.) NDC 0524-0021-16

CAUTION

Federal law prohibits dispensing without prescription.

July 1980

TWIN-K-CL™

DESCRIPTION

Each 15 ml (one tablespoonful) supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride, in a sorbital and saccharin solution.

INDICATIONS

For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Potassium and chloride are usually the salts of choice in the treatment of hypokalemia since chloride and potassium deficiencies are likely to be associated with each other.

CONTRAINDICATIONS

Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS

TWIN-K-Cl is a palatable form of oral potassium replacement. Excessive, undiluted doses of TWIN-K-Cl may cause a saline laxative effect.

To minimize gastrointestinal irritation, it is recommended that TWIN-K-Cl be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS

Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K-Cl is recommended for use in these patients.

ADVERSE REACTIONS

Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiograpic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K-Cl taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE

The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes. Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION

The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 30 to 60 mEq of potassium ions and 8 to 16 mEq of chloride ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K-Cl are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED Bottles of 1 pint (16 fl oz)

NDC 0524-0022-16

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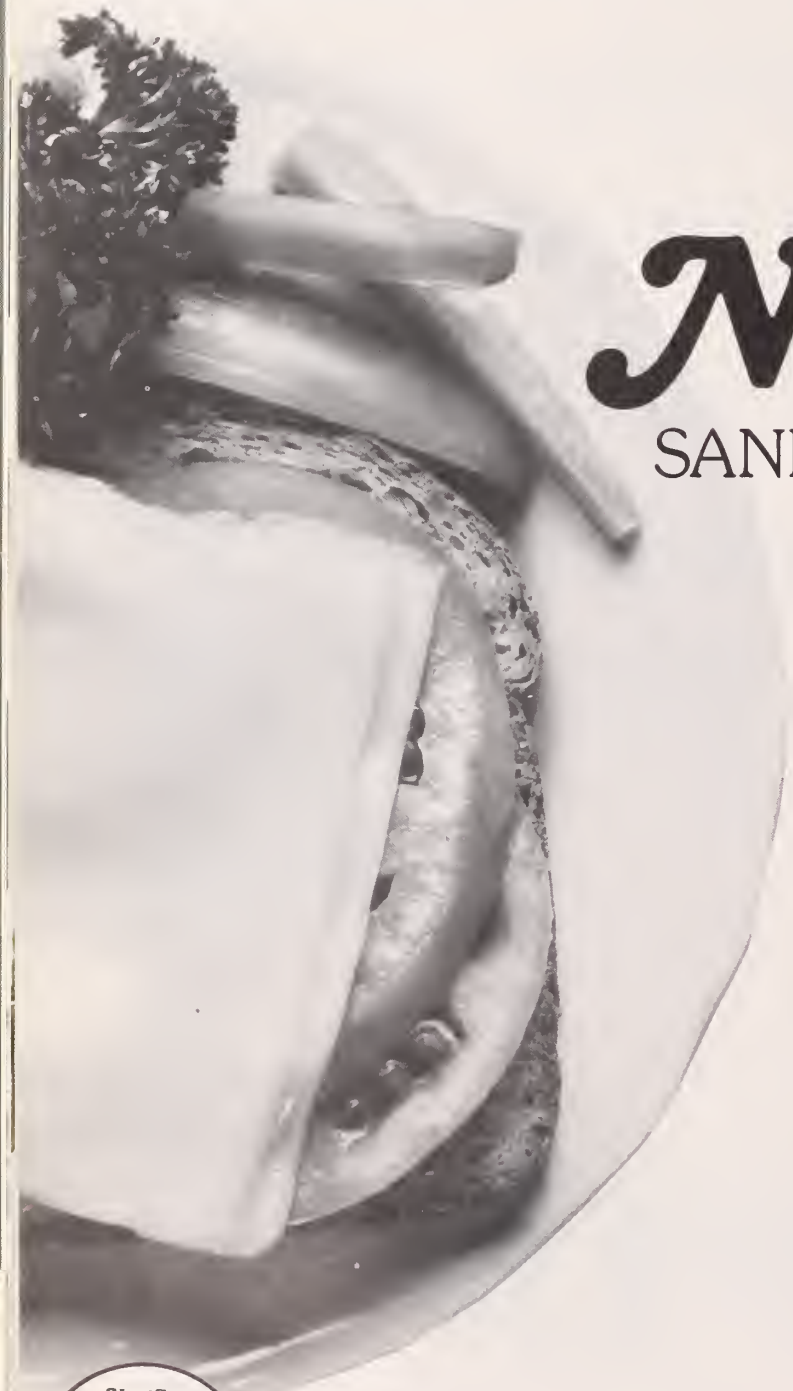
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ACF-551

DATELINE

"Health Care" On the Air

Jackson, MS - Such topics as health care costs, physical fitness, abortion, alcoholism, childhood diseases, birth control, eye disorders, kidney stones, and high blood pressure are among subjects which will be discussed during upcoming segments of "Health Care," the Burroughs-Wellcome/MSMA-sponsored radio interview shows. Local physicians are featured on the programs, which are presented each Sunday at 9:20 p.m. on Jackson radio station WSLI.

Mental Health Task Force Created

Jackson, MS - During the recent MSMA Jail Health Care Project workshop on mental health in jails, a task force of mental health practitioners and jail representatives from around the state was formed. Their goal is to assess problems and propose solutions regarding the provision of adequate mental health care for jail inmates. The task force has completed an initial planning proposal and is currently developing a survey instrument for data collection.

Dangerous Street Drug Surfaces

Jackson, MS - A drug developed in 1972 in a University of Mississippi laboratory has been blamed for at least 12 deaths in California. The drug, considered 80 times more potent than morphine, is a methyl analog of the synthetic painkiller fentanyl. The drug is not manufactured by pharmaceutical companies, but apparently is being produced illicitly by chemists who read the UM professor's animal test findings, which were published in a scientific journal in 1973.

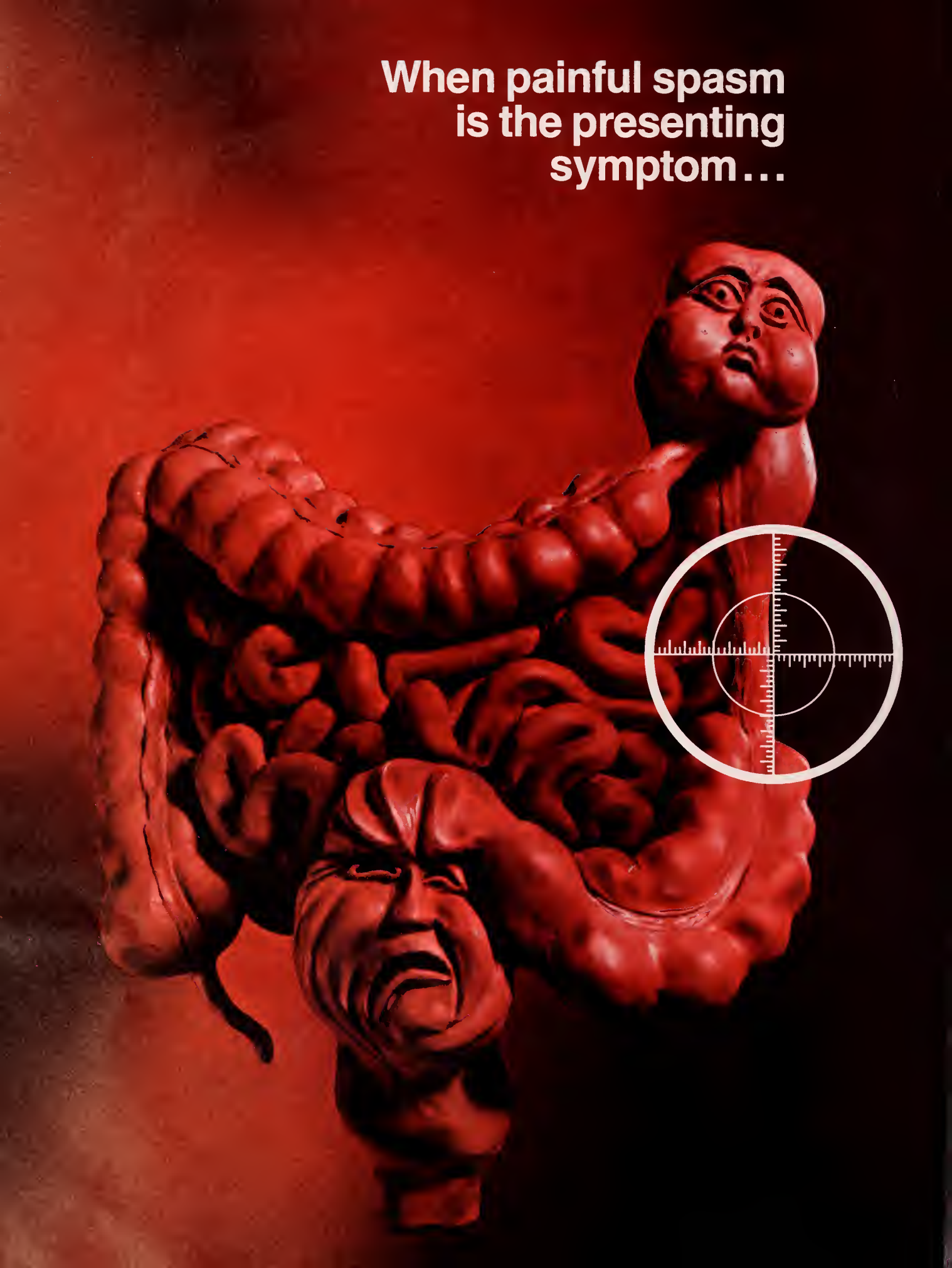
SBH Predicts Heavy Flu Season

Jackson, MS - The State Board of Health's Bureau of Disease Control has predicted a heavier than usual flu season. First estimates that some 15,000 Mississippians would suffer from flu have been revised, and now it is expected that as many as 25,000 cases could occur. The last major outbreak of flu in the state was in 1969. The State Board of Health has urged the elderly and chronically ill to check with their physicians about receiving the flu vaccine.

Parent Education Combats Drugs

Columbus, MS - To combat an increasing drug problem in the youth of this area, several community groups conducted a Drug Education Week last October which focused on parent education and awareness. Special guest was Dr. Thomas Gleaton of Atlanta, who discussed drug abuse in adolescents during a Town Meeting and described the success of a Parent Peer Group which he formed to battle a marijuana scene involving 70% of the students at one Atlanta junior high school.

When painful spasm is the presenting symptom...



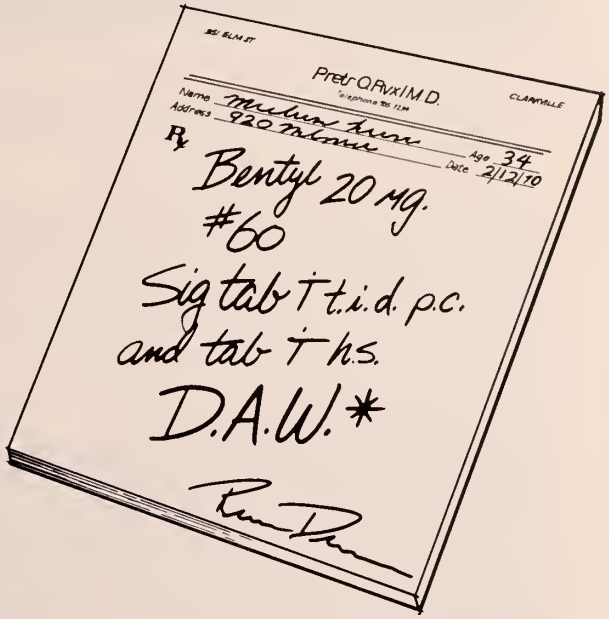
...in the functional bowel/irritable bowel syndrome†

be sure to specify

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



*D.A.W.-Dispense as written

because:

Bentyl passes these tests for product integrity.

- The Bentyl molecule is a product of original Merrell research.
- At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- Bentyl bioavailability of tablets, capsules, syrup and injectable.
- The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- Pharmacologic effect in the distal colon compared to placebo†† shows how Bentyl affects abnormal motor activity in the irritable colon patient.†

† This drug has been classified "probably" effective for this indication.

Merrell

†† In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIDNAL DISDRDERS ARE DFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATIDN DF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily (Dilute with equal volume of water.)

Bentyl 20 mg : *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENDUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

0-6546 (Y115C) MNQ 442

Tupelo Will Host Hypertension Seminar

The North Mississippi Medical Center is sponsoring a seminar on hypertension to be held Feb. 18 at the Ramada Inn Convention Center in Tupelo.

The seminar is accredited for 7 hours Category I Credit. Registration fee is $25.00.

For more information, contact Dr. Tom Wooldridge, seminar coordinator, at North Mississippi Medical Center, 830 South Gloster St., Tupelo, MS 38801.

UMC Adds to Faculty

An assistant professor and an instructor have joined the School of Medicine faculty at the University of Mississippi Medical Center.

Dr. Ellie T. Sturgis was named an assistant professor of psychiatry and human behavior and Dr. Chong Hee Park was named an instructor in anesthesiology.

UMC Vice Chancellor Dr. Norman C. Nelson announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Sturgis earned the B.A. degree at Furman University in South Carolina and the M.S. and Ph.D. degrees at the University of Georgia. She interned at the Medical University of South Carolina, the VA Hospital in Charleston, SC, and at Middlesex Hospital Medical School in London.

Dr. Park, former staff physician at the Medgar Evers Health Care Center in Fayette, holds the M.D. degree from Korea's Chonnam National Medical School. He took residency training in rehabilitation medicine at New York University Medical Center and in anesthesia at Beth Israel Medical Center. He interned at Mount Vernon Hospital.

113th Annual Session

April 26-30, 1981

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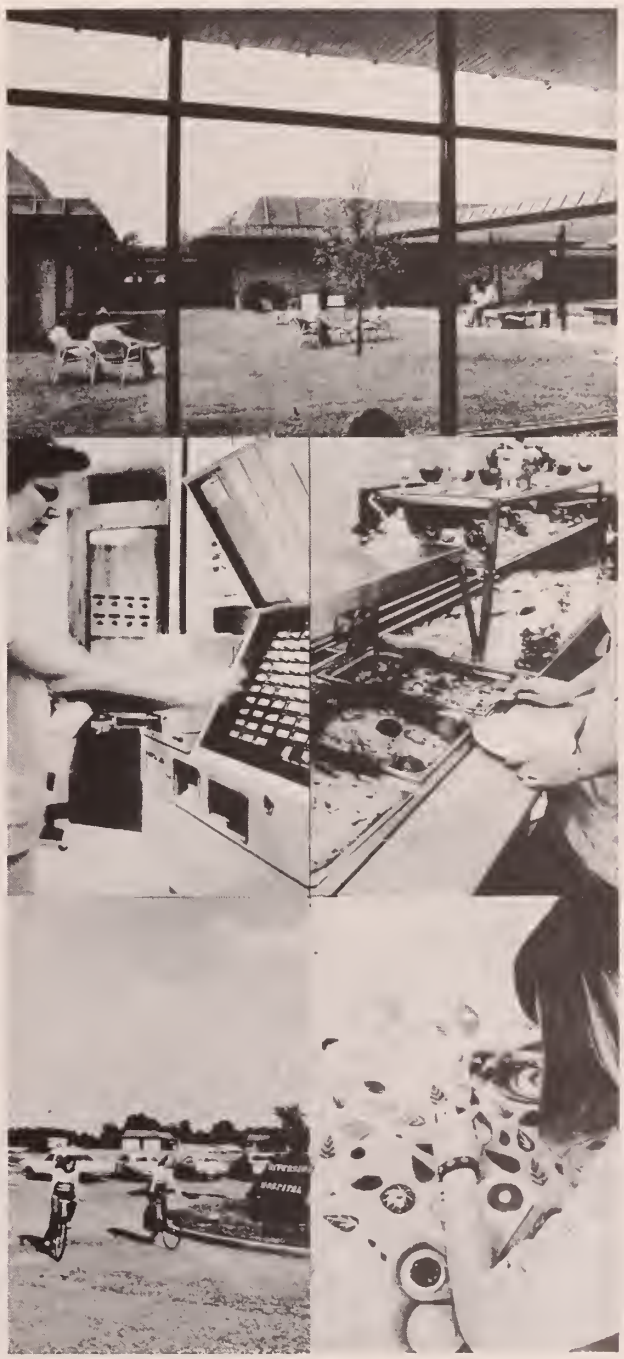
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



Riverside Hospital

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Telephone: (601) 939-9030

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SCHOOL OF
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Seminar I
February 25—March 2, 1981
Seminar II
February 27—March 2, 1981
Mardi Gras Day
March 3, 1981

Topics:

Basic Microscope Techniques
Setting Up a Lab
Acute Management of the Multiple Trauma Candidate Requiring Reimplantation
Esophageal Reconstruction with Vascularized Jejunal Interposition
Head and Neck Reconstruction Via Microsurgery
Mandibular Reconstruction with Vascularized Bones and Soft Tissues
Toe to Hand Transfers
Cancer and Microsurgery
Geometry of and Planning of Microsurgery Free Flaps
Bracheal Plexus and Peripheral Nerve Microsurgery
Intracraneal Neuromicrosurgery
Urologic Microsurgery, Including Reconstructive, Replantation and Infertility
Gynecological Microsurgery Reconstruction and Infertillty
Chest Wall Reconstruction with Microsurgery
Microsurgery and Trauma
Orthopedic Applications of Microsurgery
Microsurgery

Program:

The course consists of two seminars
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19 hours lecture and 21 hours lab, which includes basic techniques with personalized instruction from visiting faculty using Applied Fiberoptics binocular microscopes
Seminar II A lecture and video series, Friday, February 27 through Monday, March 2.
19 hours lecture and simultaneous video sessions to coincide with the labs

Accreditation:

As an organization accredited for continuing medical education, Louisiana State University School of Medicine, New Orleans, designates this continuing medical education activity as meeting the criteria for forty credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

Registration:

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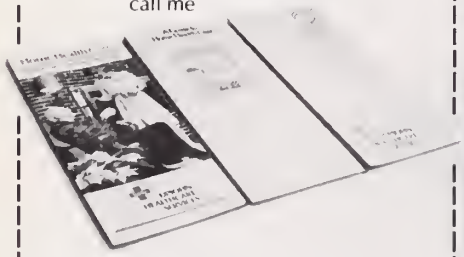
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ORIGINAL PAPERS

Ultrastructure of an Undifferentiated Neoplasm

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Jackson, Mississippi

A COMMON PROBLEM confronting pathologists is the classification of malignancies which are undifferentiated or very poorly differentiated by light microscopy. The classification of tumors is becoming increasingly important as therapeutic protocols become more sophisticated. Various special techniques, e.g. immunochemistry and ultrastructural studies, have been found helpful when correlated with the clinical setting and light microscopic appearance. This article will show how electron microscopy was helpful in elucidating the nature of such a neoplasm.

Case Report

The patient is a 56-year-old white male who complained of a "knot" in the calf of his right leg that had been present and increasing in size for seven months. Physical examination revealed a 4 x 6 cm movable, indurated soft tissue mass at the junction of the middle third and distal third of the calf. Right inguinal lymphadenopathy was evident. Excision of the mass and a right inguinal lymph node biopsy were performed.

The tumor involved the skeletal muscle and subcutaneous tissue, infiltrating within 2 mm of the overlying epithelium. By light microscopy, it was composed of compact sheets of large monotonous cells, approximately 15-20 microns in diameter. The nuclear to cytoplasmic ratio was high, and the cytoplasm was scanty due to the compact nature of the tumor (see Figures 1 and 2). Nuclei were vesicular

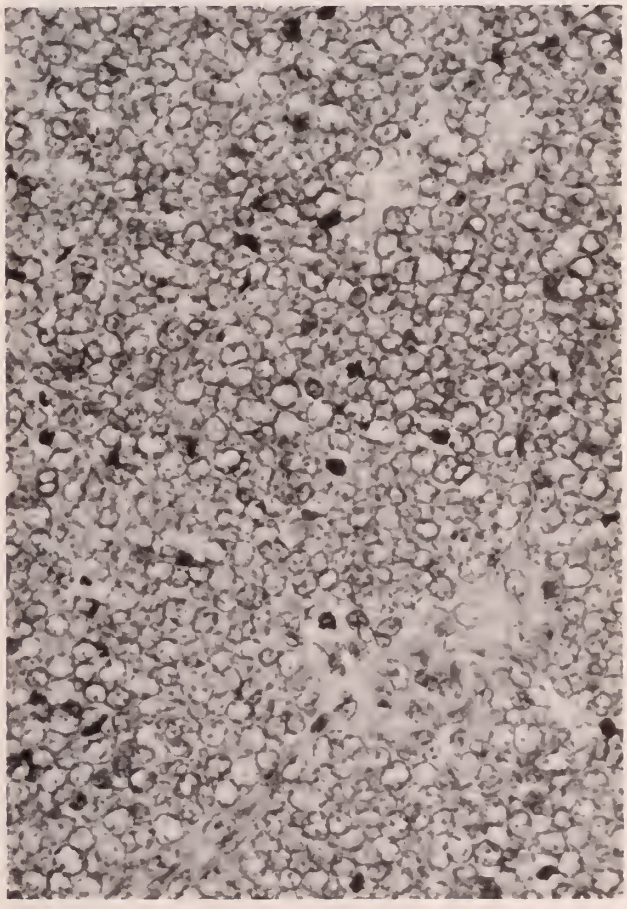


Figure 1. This paraffin embedded 6 micron hematoxylin and eosin section shows the monotonous nature of the tumor (X 500 magnification).

From the Department of Pathology, University Medical Center, Jackson, MS.

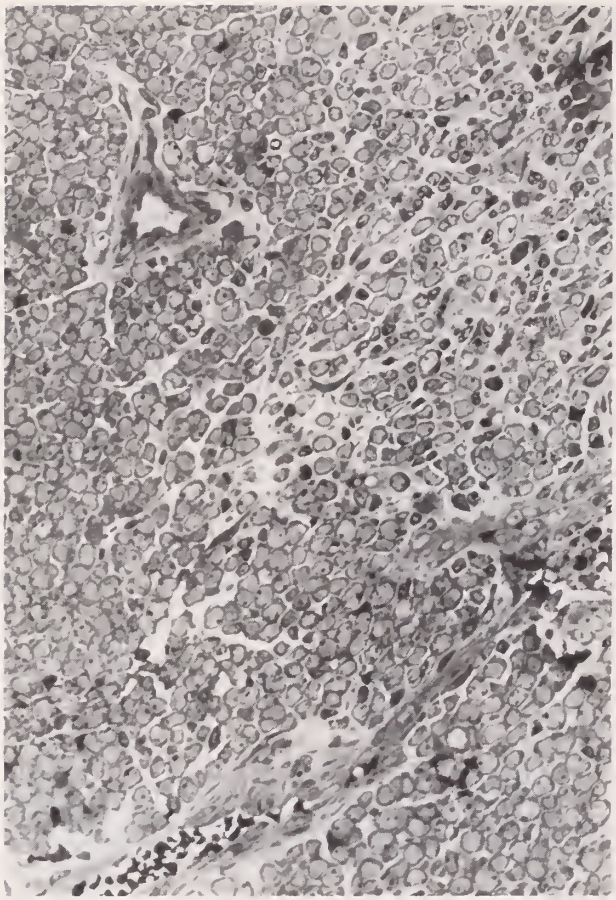


Figure 2. This epoxy resin embedded 1 micron polychrome section of the same tumor reveals considerable cytologic detail and clarity (X 500 magnification).

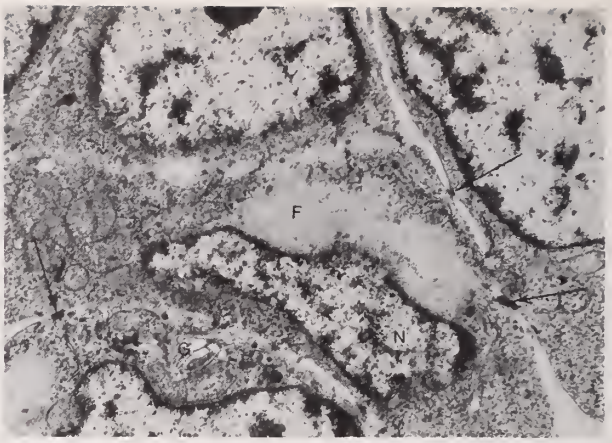


Figure 3. An electron micrograph illustrates a characteristic bundle of thick filaments (F) and several complex cell junctions (arrows). Nucleus (N). Golgi complex (G). (X 4,240 magnification).

with frequent small nucleoli. Mitotic figures were numerous. The inguinal lymph node showed complete replacement and invasion of the capsule by the same tumor. The preliminary diagnosis was malignant lymphoma, histiocytic type (reticulum cell sarcoma).

Selected pieces of tumor were minced in 1 mm cubes, fixed in phosphate buffered formalin, and then washed in phosphate buffer (pH 7.2). This was followed by post-fixation of the tissue in phosphate buffered 1% osmium tetroxide, dehydration in graded concentrations of ethanol, and embedment in epoxide resin. Ultra-thin sections were cut with a diamond knife, stained with uranyl acetate and lead citrate, and examined.

The distinguishing feature on ultrastructural studies (see Figure 3) was the presence of bundles of cytoplasmic filaments that appeared to be of the myosin "thick" type (150 A in diameter). No actin "thin" filaments (60-80 A in diameter), Z bands, or striations were found. Occasional complex cell junctions were found. The other ultrastructural features were nonspecific and might be found in any undifferentiated tumor.

Discussion

The scantiness of cytoplasmic organelles by electron microscopy confirmed the primitive nature of this neoplasm. However, conspicuous cytoplasmic filaments are characteristic of mesenchymal differentiation.[1, 2] Cytoplasmic filaments are of diagnostic value only if a particular configuration, a relationship to other structures or association with other celular features is evident. For example, smooth muscle tumors display numerous longitudinal cytoplasmic actin (thin) filaments with electron dense attachments along the cell membranes; these filaments are associated with pinocytotic vesicles beneath the cell membrane. Fibrous tissue tumors show fine microfilaments randomly dispersed throughout the cytoplasm. In skeletal muscle tumors, Morales et al maintain that the recognition of cytoplasmic filaments as the myofilaments of rhabdomyoblasts is based on the presence of both thick and thin filaments alternately arranged.[2] Abortive Z bands and cross-striations are further evidence of derivation from striated muscle. In this case, the presence of thick filament bundles alone is therefore not sufficiently strong evidence for the diagnosis of rhabdomyosarcoma, although the clinical presentation of a mass of an extremity is suggestive.

One other feature that is more supportive of a diagnosis of a mesenchymal tumor rather than lymphoma is the presence of desmosomes (complex cell

junctions).[3] Levine and Dorfman in their ultrastructural study of 16 cases of nodular lymphoma and seven cases of diffuse lymphoma described complex cell junctions only in association with dendritic cells of the germinal centers and not with lymphoid cells.[4] The presence of complex cell junctions is strong evidence against the diagnosis of a lymphoma.

In conclusion, the ultrastructural evidence of complex cell junctions and bundles of thick cytoplasmic filaments, in conjunction with the clinical presentation of a leg mass, was interpreted as evidence of mesenchymal derivation in a malignancy that is undifferentiated by light microscopy. The final pathologic diagnosis was malignant mesenchymal tumor with some features of a rhabdomyosarcoma. The diagnosis of lymphoma was excluded. ★★★

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References

1. Horvat, B. L. et al: The ultrastructure of rhabdomyosarcoma. Am. J. Clin. Path. 53:555, 1970.
2. Morales, A. R. et al: Rhabdomyosarcoma: an ultrastructural appraisal. Pathology Annual, 1972, p. 81.
3. Clark, M.A. and O'Connell, K. J.: An ultrastructural study of embryonal rhabdomyosarcoma (sarcoma botryoides) of the bladder. J. Urology 109:897, 1973.
4. Levine, G. D., and Dorfman, R. F.: Nodular lymphoma: an ultrastructural study of its relationship to germinal centers and a correlation of light and electron microscopic findings. Cancer 35:148, 1975.

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Acquired Tracheo-Esophageal Fistula Resulting From Blunt Trauma

W. WILSON DEFORE, JR., M.D. and RUSH E. NETTERVILLE, M.D.
Jackson, Mississippi

The initial reports of acquired fistulization between the tracheobronchial tree and the esophagus were post mortem, the majority resulting from neoplastic disease. Rarely has the instance of tracheo-esophageal fistula resulting from blunt trauma to the chest been described. However, fistulization between the tracheo-bronchial tree and the esophagus is well known as a result of esophageal carcinoma, mediastinal infection, radiation therapy, and intubation injuries. The trachea and esophagus share an intimate anatomic proximity which lends itself to the pathologic involvement of both structures with injury. Symptoms of acquired fistulization with traumatic injury include dysphagia and recurrent pulmonary infection. The diagnosis usually can be easily established by the ingestion of radiopaque contrast media and supplemented by bronchoscopy and esophagoscopy. The following is a case report emphasizing the clinical presentation, diagnosis and management of this interesting condition.

Case Report

The patient, L. B., a 33-year-old black male, was admitted to the hospital following a motor vehicle accident during which he sustained blunt trauma to the chest.

On admission he complained of mild chest discomfort, but had experienced no dyspnea or hemoptysis. Physical examination at this time revealed scattered basilar rales in the lungs. The chest film showed scattered areas of atelectasis. Approximately five days later he experienced hemoptysis and difficulty swallowing liquids. Physical examination was unchanged at this time. A chest x-ray showed a mild upper lobe atelectasis. He continued to experience intermittent coughing, difficulty in swallowing liquids, and production of a bloody sputum along with a low-grade temperature.

An esophagogram revealed a fistula between the esophagus and the trachea approximately four centimeters above the level of the carina. Bronchoscopy and esophagoscopy confirmed the radiologic findings.

The patient was taken to surgery and underwent a right thoracotomy. A fistula between the anterior wall of the esophagus communicating with the posterior membranous portion of the trachea four centimeters above the carina was discovered. There was considerable inflammation, fibrosis, and edema of the surrounding tissues. The fistula was dissected from the surrounding tissues, isolated and divided, and both ends oversewn with non-absorbable sutures. Postoperatively the patient was able to resume oral alimentation in ten days and experienced no further symptoms.

Discussion

Blunt trauma to the chest is an unusual cause of acquired fistulization between the tracheobronchial tree and the esophagus.[1, 2, 3, 4] The first case report of an esophageal fistula due to closed chest trauma is attributed to Vinson in 1936.[5]

Various etiologies have been reported as the primary factor in traumatic fistulization. These include fractures of the first rib,[6] blast injuries,[7] and steering wheel trauma.[8] A review of the pathophysiology associated with acquired fistulization reveals that the fistula usually presents immediately above the tracheal carina, and rarely communicates with the right or left main stem bronchus. The tear is usually linear in the vertical plane of the esophagus and trachea, and at the same anatomic level. The injury is most likely secondary to a direct compression force of the trachea and esophagus between the sternum and vertebral bodies. The membranous portion of the trachea is torn from the supporting cartilagenous

Dr. Defore and Dr. Netterville are engaged in the private practice of surgery in Jackson, MS.

framework and there is a concomitant injury to the wall of the esophagus.

The injury is most frequent in the young male and is often associated with severe intrathoracic injuries. Symptoms usually become manifest three to five days following injury, and at this time there often is coughing, hemoptysis and dysphagia, especially with the ingestion of liquids. The delay in symptomatology is due to the interval of time necessary for the ischemic line of compression to develop with subsequent fistula formation.

Physical examination may reveal subcutaneous empysema of the chest wall or neck, rales and wheezes in the lungs, a mediastinal crunch sound, and decreased breath sounds secondary to an associated hemopneumothorax.

The diagnosis can be easily established in most cases with an esophagogram. As with most suspected esophageal perforations, a water soluble contrast media is preferred over barium to prevent soilage of the mediastinum. Bronchoscopy and esophagoscopy may serve as ancillary aids to confirm the diagnosis and the site of the fistula. Chest films may reveal the presence of subcutaneous emphysema, rib fractures, atelectasis, pneumonitis or a hemopneumothorax.

Surgical closure of the tracheo-esophageal fistula should be performed when the diagnosis is made and the patient's condition is satisfactory. Preoperatively, accurate fluid and electrolyte balance, as well as antibiotic coverage should be ascertained. Poncet[9] established the feasibility of direct surgical repair of a traumatic tracheo-esophageal fistula in 1896. A tracheoesophageal fistula above the clavicular area can usually be repaired through a cervical approach. Intrathoracic tracheo-esophageal fistulae are managed through a right thoracotomy. The fistula should be identified, isolated, and divided with suture closure of the tracheal and esophageal defects with nonabsorbable suture. Pleural flaps or intercostal muscle bundles may be interposed between the tracheal and esophageal repair to help prevent recurrence. If infection is present in the mediastinal area, an esophageal exclusion and diversion procedure with chest drainage as proposed by Urschell[1] must also be considered. If there is severe associated thoracic trauma, a tracheostomy may be performed for ventilatory assistance and postoperative pulmonary management. Following surgery, antibiotic therapy is continued along with nasogastric suction and chest tube drainage. A repeat of the esophagogram is performed on the seventh to tenth postoperative day, and if the integrity of the esophagus is intact, oral alimentation may be instituted.

Summary

Acquired tracheo-esophageal fistulization due to blunt chest trauma is a rare condition. The fistula is secondary to indirect thoracic trauma with ischemic compression of the contiguous walls of the trachea and the esophagus, usually near the level of the carina. The fistula usually becomes manifest in three to five days following injury, with episodes of coughing, hemoptysis, and dysphagia from swallowing liquids. Endoscopy and radiopaque contrast studies of the esophagus with water soluble media are indicated at this time and are usually diagnostic. Once the diagnosis is established, surgical therapy should be undertaken immediately and the results should produce a permanent cure. ★★★

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References

1. Adams, H. et al: Esophago-tracheal fistula due to nonpenetrating crushing injury. J. Thoracic Surg. 15:290, 1946.
2. Albi, R. W. et al: Tracheo-esophageal fistula due to nonpenetrating injury. Am. Surg. 19:97, 1953.
3. DeBakey, M. E.: Tracheo-esophageal fistula due to nonpenetrating injury. Am. Surg. 19:97, 1953.
4. Wesselhoeft, C. W. et al: Acquired non-malignant esophago-tracheal and esophago-bronchial fistulae. Ann. Thoracic Surg. 6:187, 1968.
5. Vinson, P. O.: External trauma as a cause of lesions of the esophagus. Am. J. Digest. Dis. 3:457, 1936.
6. Holmes, T. W., Jr. and Netterville, R. E.: Complications of first rib fracture, including one each of the tracheo-esophageal fistula and aortic arch aneurysm. J. Thoracic Surg. 32:74, 1956.
7. Volk, H. et al: Tracheo-esophageal fistula due to blast injury. Ann. Surg. 141:98, 1955.
8. Michelson, E. et al: Cervical tracheo-esophageal fistula due to steering wheel injury. Ann. Thoracic Surg. 5:178, 1968.
9. Poncet, M.: Sur um cas de fistule tracheo-aesophagienne d' origine actinomycosique. Acad. Med. Paris Bull. 35:403, 1896.
10. Urschell, H. C., Jr., Razzuk, M. A., et al: Improved management of esophageal perforations — exclusion and diversion in continuity. Ann. Surg. 179:587, 1974.

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References: 1. Paulson GW: *NY State J Med* 79:193-195, Feb 1979. **2.** Hollister LE: Antipsychotic medications and the treatment of schizophrenia, chap. 9, in *Psychopharmacology from Theory to Practice*, edited by Barchas JD *et al*. New York, Oxford University Press, 1977, pp 134, 145. **3.** Domino EF: Antipsychotics: phenothiazines, thioxanthenes, butyrophenones, and rauwolfia alkaloids, chap. 25, in *Drill's Pharmacology in Medicine*, ed.4, edited by DiPalma JR. New York, McGraw-Hill Book Company, 1971, p.476. **4.** Sovner R, DiMascio A: Extrapyramidal syndromes and other neurologic side effects of psychotropic drugs, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p.1021. **5.** Donlon PT, Stenson RL: *Dis Nerv Syst* 37: 629-635, Nov 1976.

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Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy.

Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) — bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50.

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Your guide to patient management... when you decide medication is needed

How to initiate and maintain therapy

Select dosage strength appropriate for each patient

- Limbitrol 5-12.5 is recommended to minimize drowsiness and for elderly patients
- Limbitrol 10-25 may be indicated for patients who tolerate medication without undue side effects

Specify daily dosage based on symptom severity

- An initial dosage of three tablets is recommended
- Dosage may be increased to six tablets or decreased to two tablets daily as necessary
- Once a satisfactory response is obtained, patients should be continued on the smallest dose required to maintain the desired effect

Utilize dosage options to best accommodate individual patient needs

- T.I.D. or Q.I.D., familiar regimens most suited for patients who tolerate medication without undue drowsiness
- Two tablets one hour before bedtime and one tablet midday may minimize daytime drowsiness and help relieve a common target symptom — insomnia
- Entire dosage h.s. to take maximum advantage of the sedative effect

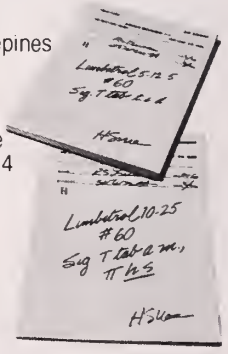
How to make each patient an informed patient

1. Discuss with patients the probability that they will experience drowsiness, especially during the first week.
2. Reassure your patients that drowsiness is one indication that the medication is working and that it may help alleviate their insomnia.
3. Encourage patients to report if drowsiness becomes troublesome so that, if necessary, dosage schedule can be adjusted.
4. Caution patients about the combined effects with alcohol or other CNS depressants. Let them know that the additive effects may produce a harmful level of sedation and CNS depression.
5. Caution patients about activities requiring complete mental alertness, such as operating machinery or driving a car.
6. Warn pregnant patients and patients of childbearing age that the safety of Limbitrol in pregnancy has not yet been established.

Please see complete product disclosure for other pertinent information.

Limbitrol should not be used under the following circumstances:

1. Hypersensitivity to benzodiazepines or tricyclic antidepressants.
2. Concomitantly with an MAO inhibitor. To replace an MAO inhibitor with Limbitrol, discontinue MAO inhibitor for a minimum of 14 days before cautiously initiating Limbitrol therapy.
3. During the acute recovery phase following myocardial infarction.



In moderate depression and anxiety

Limbitrol® IV

Relief without a phenothiazine

Radiologic Seminar CCXI: CT in Tail of Pancreas Pseudotumor Evaluation

PHILIP E. CRANSTON, M.D.
Jackson, Mississippi

PSEUDOTUMOR MEANS PHANTOM TUMOR, and radiologists have used this term for years to describe densities on images appearing to represent abnormal mass lesions. These "tumors" turn out to be normal structures, anatomical variants, or abnormalities other than tumor change. Pseudotumor cerebri refers to symptoms and physiological change suggesting an intra-cranial tumor. There is an inflammatory retro-orbital mass lesion of unknown etiology called orbital pseudotumor. The Frimann-Dahl pseudotumor was described for closed loop bowel obstruction appearing as a mass on conventional abdomen x-rays. On pyelograms, radiologists almost daily see so-called normal variant "pseudotumors of the kidneys."

A notorious area for pseudotumor change on conventional abdomen x-rays is the left upper quadrant, where the tail of the pancreas lies. The fundus of the stomach and accessory spleens may look like masses at the pancreatic tail. On regular abdominal x-ray films, bowel loops are not known for pseudotumor change at the left upper quadrant; however, after splenectomy the patient's bowel loops can drop into the splenic bed and resemble abnormal mass effects, producing confusion, particularly at the time of ultrasound examination.[1] This case is an example of pseudotumor at the tail of the pancreas produced by small bowel loops at the time of ultrasound examination in a non-splenectomized patient.

Case Report

This was the first University Medical Center admission for this 46-year-old white female with aortic valve disease and increasing congestive heart failure. There was a history of alcohol abuse, and the patient was diabetic. She was experiencing right upper quadrant pain and her alkaline phosphatase was elevated. A gallbladder series examination demonstrated gallstones. The ultrasound examination demonstrated a distended gallbladder with no stones noted, prominent hepatic veins, and possible neoplasm at the tail of the pancreas with possible pressure effect on the adjacent left kidney (see Figure 1). The non-contrast CT scan showed a small pancreas with calcifications indicating chronic pancreatitis (see Figure 2). Gallstone formation was noted. No mass was present in the tail of the pancreas, and it was felt that the demonstrated contrast-filled loops of small bowel projecting next to the left kidney produced the pseudotumor change at the tail of the pancreas (see Figure 3). The patient expired at cardiac surgery, and CT findings were confirmed at autopsy. Gallstones were found and the pancreas showed marked atrophy, fibrosis, and severe pancreatitis. Multiple small stones were noted in the pancreatic ducts and no mass lesion was found in the pancreas.

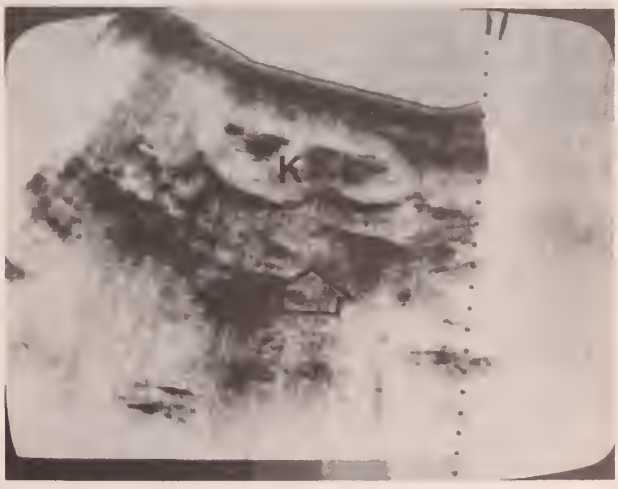


Figure 1. Ultrasound showing possible neoplasm at the tail of the pancreas with possible pressure effect on the adjacent left kidney (k). The pseudotumor is indicated by the open arrow.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center, Jackson, MS.



Figure 2. CT demonstrating chronic pancreatitis. The poorly defined pancreas is atrophied and projects between the duodenum (D) and small bowel (SB). Two calcific foci are noted at the head area. No mass is demonstrated at the tail. Aorta (A). Inferior vena cava (C).

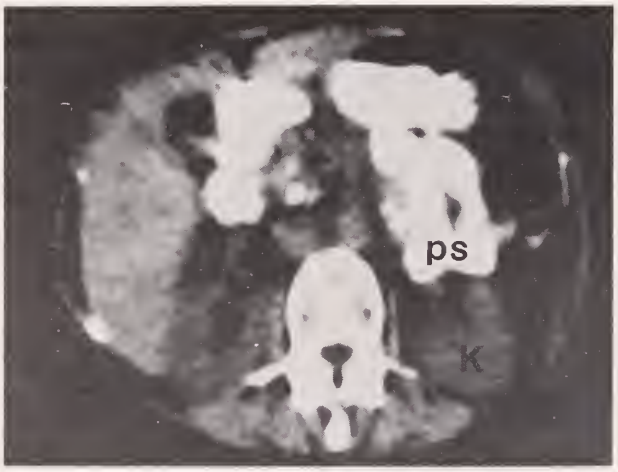


Figure 3. Small bowel loops filled with contrast media here had projected next to the kidney and produced the pseudotumor change (PS) at the tail of the pancreas region noted on ultrasound. Kidney (K).

Discussion

CT is now recognized as an excellent modality for the evaluation of pancreatic disease.[2, 3] Ultrasound, which is less expensive, can provide a definitive answer in many cases of pancreatic pathology.[2] In particular circumstances, ultrasound has definite limitations. Gas can cause considerable interference and evaluation may be incomplete or totally inadequate.[4] Gas is only a minor problem in CT scanning, and the pancreas is almost always seen in its entirety.[5] There is specific difficulty in evaluating the tail of the pancreas with ultrasound, and it is generally felt that CT can evaluate this aspect of the pancreas better.[6]

In both ultrasound and CT scanning, loops of bowel can simulate abnormal masses.[1, 2, 3] With CT, oral contrast medium is routinely given to prevent this problem, and bowel loops can be identified as such.[7] This case demonstrates the necessity of using ultrasound and CT body scanning in a complementary fashion.[2, 3] ★★★

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References

1. Lee, T. G., Forsberg, F. G. and Koehler, P. R.: Post splenectomy true mass and pseudomass ultrasound diagnosis. Radiology 134:707-711, March 1980.
2. Lee, J. K. T., Stanley, R. J., Nelson, G. L., and Sagel, S. S.: Pancreatic imaging by ultrasound and computed tomography. Radiol. Clin. N. Am. 17:105-117, April 1979.
3. Sheedy, P. F., Stephens, D. H., Hattery, R. R., MacCarty, R. L., and Williamson, B.: Computed tomography of the pancreas. Radiol. Clin. N. Am. 15:349-366, 1977.
4. Weill, R., Schraub, A., Eisenscher, A., and Bourgoin, A.: Ultrasound of the normal pancreas. Radiology 123:417-423, 1977.
5. Stanley, R. J., Sagel, S. S., and Levitt, R. G.: Computed tomographic evaluation of the pancreas. Radiology 124:715-722, 1977.
6. Doust, B. D. and Pearce, J. D.: Grey-Scale ultrasonic properties of the normal and inflamed pancreas. Radiology 120:653-657, 1976.
7. Moss, A. A., Kressel, H. Y., Korobkin, M., Goldberg, H. I., Rohlfing, B. M., and Breech, R. C.: The effect of gastrografin and glucagon on CT scanning of the pancreas: A blind clinical trial. Radiology 126:711-714, 1978.
8. Ferrucci, J. T., Wittenburg, J., Block, E. B., Kirkpatrick, R. H., and Hall, D. A.: Computed tomography in chronic pancreatitis. Radiology 130:175-182, January 1979.

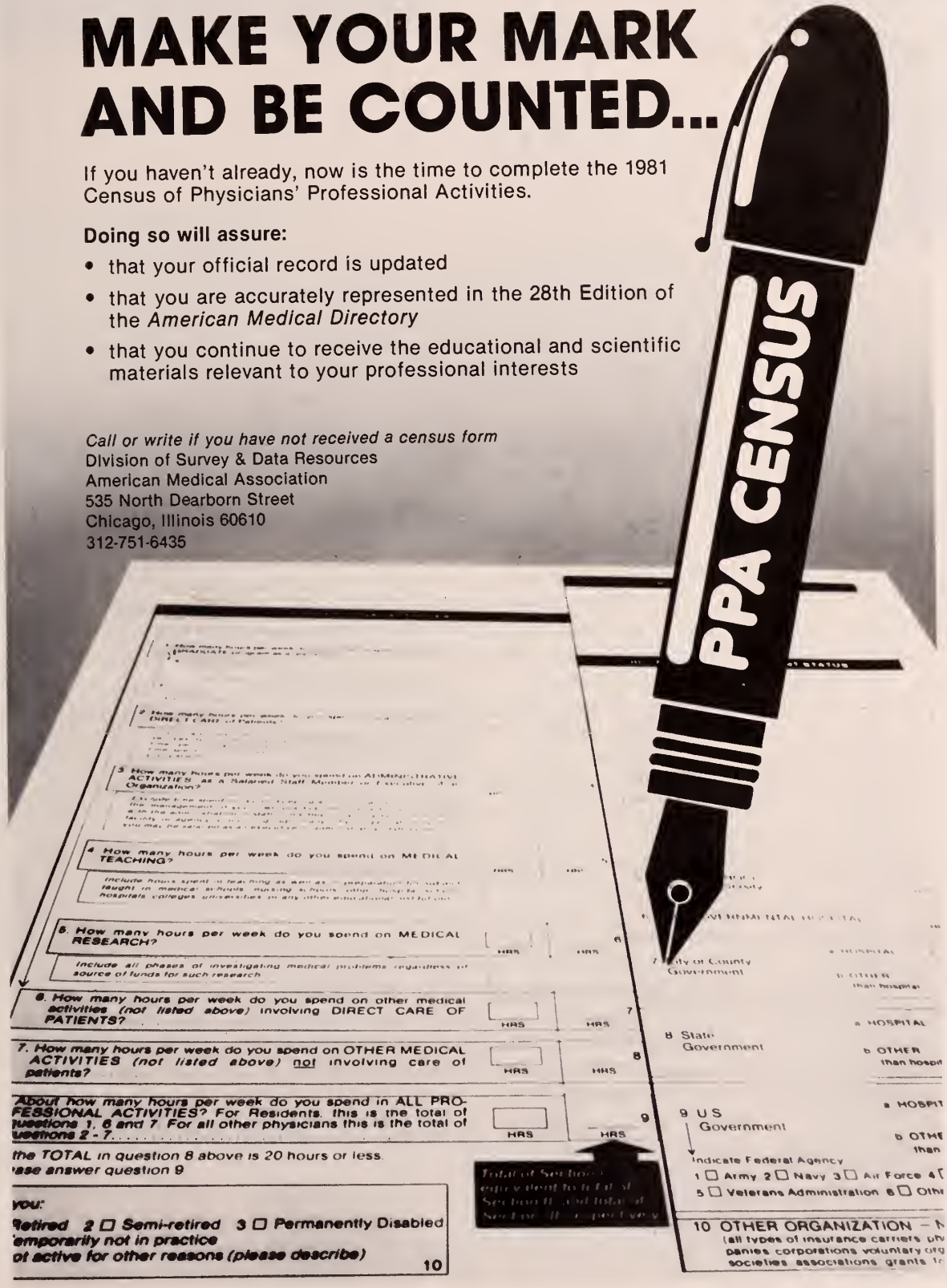
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The President Speaking

Come to the Coast!

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

The Mississippi Gulf Coast may not be the garden spot of the world, but for us who live here, it is pretty great. There are many reasons I could give why you should visit the Coast, but the one that I would like to emphasize at the present time is the 113th Annual Session of the MSMA, which will be at the Biloxi Hilton April 26-30. You should note that this is slightly earlier than in previous years.

The Annual Meeting on the Coast has always been important to me, but as your President, it has added interest to me for the coming session. All of us like to feed our ego, so needless to say, a large turnout would give me bragging rights. I thought I may as well mention this, for I know some of my "real buddies" would remind me of my motive.

This should be an ideal time for a visit to the Coast. You owe a week of fun, frolic, politics, and education to yourself and family. After all, you will have just completed a hard winter's work. If you have never attended an Annual Session, I would doubly urge you to attend. See for yourself firsthand the workings of your state organization. Attend the Reference Committee meetings and put in your two dollars' worth (inflation). You do not have to be a delegate to do this. You may even get permission on the floor of the House of Delegates to express your views there.

What an ideal time to see those ole classmates that you could hardly endure and wondered how they got in Med School — much less *out!* Call them now and set up an evening of entertainment, a tennis match, or golf foursome. As we all have a common goal and belong to the same organization, we might learn to respect them, even if we do not care to take a cruise together.

As you can see, there are many reasons why you should mark your calendar, arrange coverage, and make reservations for a week's vacation on the beautiful Mississippi Gulf Coast. You will be glad you did, and the MSMA will be one year older and a lot stronger as a result of your participation.

RUSH! RUSH! RUSH! Don't be a tail dragger. If you are not careful, golf, tennis, entertainment, and hotel reservations will be depleted before your executive secretary can make all the arrangements. See you in Biloxi.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 2

FEBRUARY 1981

Editors Encourage Comments, Solicit Scientific Articles

Your Publications Committee and editorial staff of the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION are committed to publishing a quality journal which meets the needs of the membership. Meeting these goals, with increasing inflation and decreasing numbers of papers submitted for publication, is challenging. We are, however, committed to continue giving you a quality publication and not follow in the steps of several other state journals and discontinue the publication of scientific papers, offering only editorial comments, personals, association business, and similar items. This is being done by an increasing number of state journals because of the difficulty in securing quality papers of interest to their membership.

To assist us in our efforts, we encourage comments regarding your journal and solicit from the membership scientific material of interest to a large portion of our readers. While not wanting to become specialty oriented, articles relating to a specialty, but of general interest, are of value.

In keeping with these goals, we will begin publishing on an intermittent basis the Obstetrics and Gynecology Grand Rounds from the University Medical Center. Hopefully, this publication will be of sufficient interest to our readers to warrant its continuation and will possibly encourage submission of similar material from other sources.

MYRON W. LOCKEY, M.D.
Associate Editor

GUEST EDITORIAL

A Different View

(Ed. Note: The following article is reprinted from the Lake City (SC) News and Post. The author is freelance writer Jack Gable, nephew of former MSMA president Gerald Gable.)

I witnessed a sort of miracle the other night. Well, it may not have been a miracle, but it was something special. It involved the saving of a life.

I happened to be at a Charleston hospital when a man was dying. It was obvious. His gasps for breath were so loud that they could be heard over the entire hospital floor. The scene was tragic.

Five nurses and a doctor struggled to keep a patient alive in what seemed like a vain attempt to get the man to the intensive care unit. The only voice which could be heard over the patient's breathing was that of the doctor who gve instructions and called for equipment. The nurses moved quickly and silently. Passers-by hesitated only momentarily, and then hurried along. They knew death hovered there.

The patient's breathing stopped again and again, but again and again it was restarted with respiratory devices. The sorrow in the doctor's eyes told the story. His patient was slipping away.

The family stood nearby and sobbed silently. The world was surreal for them.

But, some thirty feet away, there stood a man. He was fairly ordinary looking man but, as fate would have it, the life of the patient would pivot on him, and him alone. He seemed to be nonchalantly scanning some files at the nurses station, only glancing up at the tragedy occasionally. His apparent blase attitude was a false impression.

The doctor who worked over the patient knew that he was over his head. He was involved in a family practice and the problems he faced now were of a highly specialized nature. He could not save the man, and he knew it. And so his eyes looked up, searching; searching for that one chance in a million that someone would be there at that moment who could do what he could not. The man was there, standing at the desk. The call went out.

The man at the desk moved quickly and professionally. There, in the hallway of the hospital, he established an alternate, substitute airway for the patient, and accompanied the patient to the intensive care unit of the hospital. And just as suddenly as he appeared, he disappeared into the night, without

waiting for the thanks of the accolades which were to be his.

Later it was discovered that the man's name was Dr. Frank Schabel, an anesthesiologist. He was a doctor specialized in keeping people in critical condition alive. He confided in a nurse that he had finished his work at the hospital but that he "hung around" because "I knew they'd need me." Such men are so rare in the "ME" generation.

Another question which always arises in our often cynical generation concerns cost. "What did he charge?" we ask. The answer is nothing — nothing at all. If there are really stars placed in heavenly crowns, Dr. Schabel has one heck of a shiner.

Medico-Legal Brief

Hospital Liable For Granting Physician Privileges

A hospital was liable for negligence in granting orthopedic privileges to a physician, a Wisconsin appellate court ruled.

The physician operated on a 17-year-old patient on July 11, 1975, to remove a pin fragment from the patient's right hip. During the operation the patient's right femoral artery and nerve were severed. The injury caused permanent paralysis of his right thigh muscles, with resultant atrophy, weakness and loss of function. He filed suit against the operating physician and the hospital. Prior to trial, he settled the action against the physician for $140,000.

The trial proceeded and the jury found the physician negligent and attributed 20 per cent of the negligence causing the patient's injury to him. The jury also found the hospital negligent in granting the physician staff privileges and apportioned 80 per cent of the causal negligence to the hospital. Damages were awarded in the sum of $315,000 for personal injuries, past and future, and $90,000 for impairment of earning capacity, past and future.

Affirming the decision, the appellate court said that the hospital did not adhere to its own procedures for approving the credentials of staff applicants. On the physician's application for staff privileges the physician indicated that he was on the active staff of another hospital with full orthopedic privileges and held consultant privileges at two other hospitals. He also stated that his privileges had never been suspended, diminished, revoked or not renewed at any hospital. He also failed to answer any questions about malpractice liability.

Contrary to his statements on the application, the physician's privileges had been curtailed and severely restricted. There was also no evidence that he had ever been associated with two of the hospitals he mentioned in his application. Nevertheless, he was granted staff privileges and later elected chief of the medical staff.

The appellate court said that the evidence supported the jury's apportionment of negligence and award of damages. The patient's occupational opportunities were severely restricted by his injuries, the court noted. — *Johnson v. Misericordia Community Hospital,* 294 N.W.2d 501 (Wis.Ct. of App., May 12, 1980)

CME Workshop Planned

MSMA and the Louisiana Medical Society will co-sponsor a "How to Do It" workshop for CME directors, coordinators and hospital administrators on Feb. 21-22 at the Broadwater Beach Hotel in Biloxi. Local and national speakers will conduct the workshop. Registration materials have been mailed to all Mississippi hospitals. For further information contact MSMA headquarters, P.O. Box 5229, Jackson, MS 39216; telephone 800-354-5433.

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Council Announces First Annual James Grant Thompson Memorial Lecturer

Gerald Weissmann, M.D., professor of medicine at New York University School of Medicine, will deliver the First Annual James Grant Thompson Memorial Lecture during MSMA's 113th Annual Session in Biloxi.

Dr. Weissmann will present a paper on "Prostaglandins in Acute Inflammation" during the scientific session of the Section on Family Practice, Wednesday, April 29.

"We are pleased that Dr. Weissmann has accepted the invitation to deliver the first Thompson Memorial Lecture," said Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly, which is charged with planning the Annual Session. "The lecture will be presented each year during Annual Session and will rotate among the Sections on Family Practice, Medicine and Surgery," he explained.

The family of Dr. James Grant Thompson established the memorial lectureship in honor of Dr. Thompson — civic leader, pioneer in the field of dermatology, and former president of the Mississippi State Medical Association.

"The Mississippi State Medical Association appreciates the Thompson family's continuing interest in association activities as evidenced by their sponsoring this lectureship," said Dr. Sidney O. Graves of Natchez, chairman of the Board of Trustees. "The Thompson lecturers will be chosen based on their contributions to medical science which have benefitted the public and brought acclaim from professional colleagues and will undoubtedly make an outstanding contribution to the association's program of scientific education."

Dr. Weissmann received his B.A. degree with Honors from Columbia College and his M.D. degree from New York University College of Medicine in 1954. He interned at Mount Sinai Hospital of New York and served residencies in medicine at Mount Sinai Hospital and Bellvue Hospital. He has been on the faculty of New York University School of Medicine since 1959 and has been director of the Department of Medicine's Division of Rheumatology since 1973.

Dr. Weissmann holds membership in numerous professional societies and serves on the editorial boards of *Inflammation, Advances in Prostglandin and Thromboxane Research, Clinical Immunology and Immunopathology, American Journal of Medicine, Age, Tissue Reactions,* and *Infectious Diseases.*

In 1980 Dr. Weissmann received the Solomon A. Berson Medical Alumni Achievement Award in the Clinical Sciences. Other honors include: the Lila Gruber Cancer Research Award (with Emil Frei, Jr.) in 1979; the University of Bologna Medal in 1978; the Marine Biological Laboratory Award for best paper of the year in 1974 and 1979; the Alessandro Robecchi Prize for Rheumatology, Aix-les-Baines, in 1972; and a Guggenheim Fellowship in 1973.

He has authored or co-authored some 140 scien-



Gerald Weissmann, M.D. will deliver the First Annual James Grant Thompson Memorial Lecture during MSMA's 113th Annual Session.

tific reports and some 120 reviews, chapters, films and essays. Eight books bear his name as editor.

Following the lecture, Dr. Weissmann will participate in a panel discussion with other speakers scheduled for the Section on Family Practice scientific program, according to Dr. Frank W. Bowen of Carthage, section chairman. Other speakers are: Dale E. Hammerschmidt, M.D., of Minneapolis, assistant professor of medicine at the University of Minnesota Hospital, who will present a paper on "Immune Bases of Atherosclerosis, Shock Lung, and Other Disorders"; Alan M. Lefer, Ph.D., of Philadelphia, PA, professor and chairman of the Department of Physiology at Jefferson Medical College, who will present "Cardiovascular Actions of the Prostaglandins in the Treatment of Shock"; and William S. Nicholas, M.D., of Jackson, associate professor of medicine at University of Mississippi Medical Center, who will present "Management of the Insulin Dependent Diabetic Patient" and "Management of the Insulin Independent Patient."

Three "Meet the Professor" breakfasts featuring Drs. Nicholas, Hammerschmidt and Lefer will precede the Thompson Lecture.

Dr. David Guyton Presents Annual Strabismus Course



Dr. David L. Guyton, left, assistant professor of ophthalmology at Johns Hopkins University School of Medicine, presented the third annual course on strabismus at the University of Mississippi Medical Center. Course coordinator was Dr. R. E. Valenzuela, UMC professor of surgery (ophthalmology). The Jackson Central Lions Club sponsored the continuing education offering for physicians with the UMC Department of Surgery (Division of Ophthalmology) and the UMC Division of Continuing Health Professional Education. Dr. Guyton is the son of Dr. Arthur C. Guyton, chairman of the UMC Department of Physiology and Biophysics.

Board Adopts 1981 Budget, Studies New MSMA Projects

MSMA's Board of Trustees held its regular fall meeting in Jackson on December 18 and considered a lengthy agenda which included the association's 1981 budget.

The Board adopted a budget of $1,039,960 for association operations during 1981 to include projected AMA dues transmittals totaling $337,500. The association was expected to show a plus balance in operations for both 1980 and 1981, thus preventing a dues increase in spite of a projected inflation rate over the two year period of some 24 percent. The budget report also indicated a continued increase in membership and noted an annual increase in membership since 1975.

The Board reviewed legislation to be considered by the 1981 Mississippi Legislature, particularly as it related to the expansion of the roles and proposed licensure of various allied health professions and stated that the association would call for a moratorium on all such legislation until such time as this matter was studied and a consistent policy adopted.

The association's AMA delegates reported on activities of the AMA House of Delegates at its December meeting in San Francisco. They noted that a Mississippi resolution calling on the AMA to continue its court battle to obtain the right to prescribe ethical principles for its members was adopted. It was also reported that the AMA delegates, by a vote of 104-100, had gone on record for repeal of all government supported peer review and called on the profession to continue to support its review of the quality, necessity and appropriateness of medical services.

The Board reviewed a project to consider the present and future building needs of the association and authorized continued study of the project under the direction of a committee of the Board.

The Board also appointed a Health Education Committee under the direction of the president to recommend criteria for health education programs in Mississippi schools.

The administrator of the association's group insurance programs met with the Board to discuss the status of those programs. The Board acted to consider new group insurance programs for the membership.

Representatives of the University Medical Center, Mississippi Academy of Pediatrics and Mississippi Ob-Gyn Society met with the Board to seek MSMA endorsement of a new $25,000,000 perina-

tal center at the UMC. The Board officially went on record in support of the proposed center.

The Board considered a corporate visitation program implemented by the AMA and other state associations which has as its purpose to meet with representatives of major corporations in the state to discuss health issues facing employers and employees. The Board acted to implement the program under the direction of the president and president-elect.

In other actions, the Board officially commented on proposed cutbacks in the Medicaid program, received a report on implementation of the MSMA-Burroughs Wellcome radio health interview show in Jackson, and heard a report from the president on membership recruitment plans.



For the 17th consecutive year MSMA will operate the Emergency Medical Care Unit during the Regular Session of the Mississippi Legislature. Staffing the EMCU will be Mavis Barlow, R.N., of Florence, who is pictured above with Senator George Smith of Long Beach. Physician services will be provided by volunteer Doctors of the Day.

Lions Clubs Give Crib-o-gram to UMC



The Lions Clubs of Mississippi have given the University of Mississippi Medical Center a crib-o-gram, a computerized device to test the hearing of newborns. Dr. Ojus Malphurs, left, director of the UMC communicative disorders laboratory, and Dr. Phil Rhodes, right, newborn center director, explain the machine to Hal Johnston, center left, and Jack Prim, center, Lions district governors. William Newell, second from right, is director of University Hospital.

Postgraduate Surgical Forum Faculty Is Announced

An internationally-recognized guest faculty will present the University of Mississippi Medical Center's eighth annual Postgraduate Surgical Forum slated for March 12-14 at the Holiday Inn Downtown in Jackson.

Sponsors are the UMC School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Guest faculty joining UMC faculty members in presenting the three-day program are Dr. Anthony Buschi, assistant professor of radiology and co-director of the Department of Ultrasound, University of Virginia School of Medicine; Dr. William H. Edwards, clinical associate professor of surgery, Vanderbilt University; Dr. Ben Eiseman, professor of surgery, University of Colorado School of Medicine; Dr. Stanley R. Friesen, professor of surgery, University of Kansas School of Medicine; Dr. Paul H. Jordan, professor of surgery, Baylor College of Medicine; and Dr. Robert L. Kistner, associate professor of surgery, John A. Burns School of Medicine, University of Hawaii.

Also, Dr. Harold E. Kleinert, clinical professor of surgery (orthopaedics), University of Louisville School of Medicine; Dr. Richard G. Martin, head of the Department of Surgery, M. D. Anderson Hospital and Tumor Institute; Dr. William McGarity, pro-

fessor of surgery, Emory University School of Medicine and chief of surgery, Emory University Hospital; Dr. Francis C. Nance, professor of surgery and professor of physiology, Louisiana State University School of Medicine; Dr. Hiram C. Polk, professor and chairman of surgery, University of Louisville; and Dr. Herbert J. Proctor, professor of surgery and head of the trauma section, University of North Carolina at Chapel Hill School of Medicine.

Registration fee is $225. Advance registration is required. The program meets criteria for 17 contact hours in Category I of the Physician's Recognition Award of the American Medical Association.

Breakfast sessions will be presented at 7:00 a.m. on March 13. Participants may choose programs in shock, endocrinopathies, pediatric surgery, vascular problems and inflammatory bowel disease. These programs carry one contact hour credit.

Spouses are cordially invited to attend the reception on March 13 featuring dance music and a buffet. Spouses may also participate in tours, lunches, shopping and lectures on March 12 and 13.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

Boston Physician Delivers Batson Memorial Lecture



Dr. Johnathan Bates, center, was the 1980 Claude L. Batson Memorial Lecturer at the University of Mississippi Medical Center. He is director of emergency medicine at Children's Medical Center in Boston. Dr. Bates' visit at the Medical Center coincided with the annual meeting of the Mississippi Chapter of the American Academy of Pediatrics. Dr. David Watson, left, UMC professor of pediatrics, is chairman of the Mississippi chapter. Dr. Shelby Smith, a pediatrician from McComb and a 1966 School of Medicine graduate, was at the Medical Center for the academy meeting.

NEW MEMBERS

Addison, Hollard M., Jr., Jackson. Born Baton Rouge, LA, April 28, 1951; M.D., Louisiana State University School of Medicine, New Orleans, 1977; interned Moses H. Core Hospital, Greensboro, NC, one year; internal medicine residency, same, 1978-80; elected by Central Medical Society.

Bear, Leslie H., Jackson. Born Jackson, MS, Aug. 23, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Baylor and Methodist Hospital, Houston, TX, one year; medicine residency, Ochsner Hospital, New Orleans, 1972-73; medicine residency, LSU Hospital, Shreveport, 1975-76; ophthalmology residency, same, 1978-79; fellowship in glaucoma and neuro-ophthalmology, University of Connecticut, Farmington, CT, 1979-80; elected by Central Medical Society.

Cook, John Joseph, Pearl. Born Meridian, MS. Sept. 5, 1947; M.D. University of Mississippi School of Medicine, Jackson, 1972; interned and general surgery residency, University Medical Center, Jackson, 1972-78; elected by Central Medical Society.

Guest, Roland P., Jr., Tupelo. Born Memphis, TN Nov. 2, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned, medicine residency and cardiology fellowship, University Medical Center, Jackson, 1976-80; elected by Northeast Mississippi Medical Society.

Hubbard, James R., Jr., Pontotoc. Born Pontotoc, MS, Feb. 13, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned Parkland Memorial Hospital, Dallas, one year; elected by Northeast Mississippi Medical Society.

Hull, Edgar Warren, Jr., Pascagoula. Born New Orleans, LA, Oct. 15, 1940; M.D. Yale University School of Medicine, New Haven, CT, 1965; interned Johns Hopkins, Baltimore, MD, one year; medicine residency, same, 1966-67; medicine residency, National Cancer Institute, Bethesda, MD, 1967-70; oncology fellowship, Charity Hospital, New Orleans, 1970-71; elected by Singing River Medical Society.

Ivancic, Milan E., Tupelo. Born Cleveland, OH, Sept. 25, 1949; M.D. St. Louis University School of Medicine, St. Louis, MO, 1975; interned Naval Regional Medical Center, Philadelphia, PA, one year;

pediatric residency, National Naval Medical Center, Bethesda, MD, 1976-78; elected by Northeast Mississippi Medical Society.

JAMCHUK, ANTONIO, Aberdeen. Born Argentina, Feb. 28, 1931; M.D., Universidad Nacional del Litoral, Rosario, Santa Fe, Argentina, 1956; interned, same, one year; surgery residency, Nacional Del Centernario, Rosario Clinica, Pergamino Buenos Aires, 1959-66; surgery residency, University Medical Center; elected by Northeast Mississippi Medical Society.

JAMCHUK, NANCY A., Aberdeen. Born Santa Fe, Argentina, Oct. 22, 1934; M.D., Universidad Nacional del Litoral, Rosario, Santa Fe, Argentina, 1958; interned, same, one year; pediatric residency, Hospital Nacional Del Centenario Clinica Centro, Pergamino, Buenos Aires, 1959-66; residency University Medical Center, Jackson; elected by Northeast Mississippi Medical Society.

JORDAN, ROBERT LEE., JR., Pontotoc. Born Newton MS, Jan. 3, 1949; M.D. University of Mississippi School of Medicine, Jackson, 1979; interned , same, one year; elected by Northeast Mississippi Medical Society.

KEISTER, THOMAS LEE, JR., Canton. Born Nov. 25, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned, same, one year; elected by Central Medical Society.

LEE, JOSEPH RILLENS, Bay St. Louis. Born Opelousas, LA, Jan. 18, 1946; M.D., Louisiana State University School of Medicine, New Orleans, 1970; interned Charity Hospital New Orleans, one year; surgery residency, same, 1975-78; elected by Coast County Medical Society.

MARSH, GEORGE ALBERT, JR., Meridian. Born Philadelphia, PA, Dec. 8, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned, same, one year; pediatric residency, same, 1977-79; elected by East Mississippi Medical Society.

PACE, AMUEL CARROLL, Tupelo. Born Grenada, MS, July 28, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, one year; medicine residency, same, 1976-78; elected by Northeast Mississippi Medical Society.

PARKER, JUDITH G., Brandon. Born Hattiesburg, MS, Sept. 7, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned and

How do you manage anorectal barbed fire?

95% of colon/rectal surgeons surveyed* add TUCKS® pads concomitantly to preferred suppository/ointment/cream medication for best results...

In Acute Hemorrhoidal Flare-up Prescribe Anti-inflammatory

Anusol-HC®

suppositories/cream
with hydrocortisone acetate...

the #1 prescribed product** for external and internal hemorrhoids and other common anorectal disorders

Plus

Soothing, cooling, comforting

Tucks®

The #1 premoistened hemorrhoidal pad* for added external relief and gentle cleansing of fecal residue that can irritate tender anorectal tissue.

Please see following page for full prescribing information.

PARKE-DAVIS
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Morris Plains, NJ 07950 USA
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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

PD-400-JA-0146-P-1 (1-81)

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads
Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
Vaginal Uses–Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

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pediatric residency, same, 1970-73; elected by Central Medical Society.

PEIKLIK, JOHN RICHARD, Jackson. Born Livorno, Italy, Sept. 2, 1947; M.D., University of Texas Medical School, Houston, 1977; interned and medicine residency, University Medical Center, Jackson, 1977-80; elected by Central Medical Society.

PRATHER, JOHN WAYNE, Corinth. Born Selmer, TN Jan. 23, 1943; M.D., University of California, San Diego, La Jolla, CA, 1972; interned University of Alabama, Birmingham, one year; medicine residency, same, 1973-76; cardiology fellowship, same, 1976-77; elected by Northeast Mississippi Medical Society.

STEWART, WILLIAM ROBERT, Jackson. Born Greenwood, MS, July 2, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Roanoke Memorial Hospital, Roanoke, VA, one year; orthopedic residency, University Medical Center, Jackson, 1974-76; orthopedic surgery residency, Duke University, Durham, NC, 1976-79; fellowship Scottish Rite Hospital for Crippled Children, one year; elected by Central Medical Society.

WHITACRE, R. GREER, Hattiesburg. Born Greenville, MS, Apr. 21, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned Baroness Erlanger Hospital, Chattanooga, TN, one year; radiology residency, University Medical Center, Jackson, 1976-79; elected by South Mississippi Medical Society.

PERSONALS

JAMES L. ACHORD of UMC recently attended an executive committee meeting of the American College of Gastroenterology in New York.

WALLACE CONERLY of UMC attended a recent meeting of the board of trustees, National Board for Respiratory Therapy, in Dallas.

ROBERT CURRIER of UMC was awarded the Distinguished Service Plaque by the Mississippi Council on Epilepsy.

DANIEL P. DARE of Vicksburg has been named a diplomate of the American Board of Orthopaedic Surgery.

Robert Moreton Davis of Brookhaven announces the opening of his office for the practice of ear, nose, throat, head and neck surgery and allergy at Hospital Plaza Medical Building, 1024 Biglane Drive.

John D. Dyer of Houston was honored recently with "Dr. Dyer Day" for his 40 years of medical service.

James Hardy, William Neely and Ralph Vance of UMC presented papers at the Southern Surgical Association meeting in Palm Beach, FL in December.

Frederick Heckler of UMC was visiting professor at the University of Pittsburgh School of Medicine and invited speaker for the Pittsburgh Plastic Surgical Society in November.

Donald A. Hopkins and Michael E. Moses of Biloxi announce the association of Tom Peurifoy for the practice of general and peripheral vascular surgery.

James Hughes of UMC lectured on the AO method of internal fixation in Los Angeles November 30-December 5.

Herbert Langford of UMC chaired a symposium on mild hypertension for the American Heart Association in Miami, FL, in November.

Frank Nichols of Tupelo announces the opening of his office for the practice of cardiovascular and thoracic surgery at 609 Brunson Drive.

Richard W. Pharr announces the opening of his office for the practice of ophthalmology at Crossgates Medical Plaza, Suite 1400, 348 Crossgate Boulevard, Brandon.

Somprasong Songcharoen and Douglas E. Gorman announce the opening of an office for the practice of plastic and reconstructive surgery and hand, cosmetic, head and neck surgery at Crossgates Medical Plaza, Suite 1500, 348 Crossgate Boulevard, Brandon.

Roy Wilson of UMC participated in a December meeting of the National Board of Respiratory Therapy in Dallas.

John R. Young of Natchez announces the relocation of the Ear, Nose and Throat Clinic, P.A., to Physician's Plaza, 151 Jefferson Davis Boulevard.

When anorectal fires cool...

Continue therapy with Anusol® Suppositories/Ointment to help maintain relief of hemorrhoidal or other anorectal symptoms

Plus

Soothing, cooling Tucks® Premoistened hemorrhoidal/vaginal pads for temporary relief of occasional external anorectal itching/burning and regular hygienic care.

Tucks, Anusol and Anusol-HC®– No.1 Physician-Preferred Products for Anorectal Care

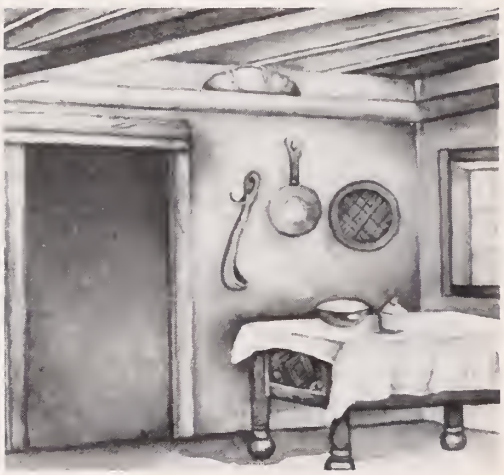
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PD-400-JA-0146-P-1 (1-81)

Yesterday's Folk Remedy:

A rye loaf in the rafters.



Early in this century in Central Europe, almost every farm family kept a loaf of moldy rye bread on one of the kitchen beams. When any family member was cut or bruised, it was an old custom to cut a thin slice from the outside of the loaf, mix it into a paste with water, and apply it to the wound with a bandage. It was believed that no infection would then result from the cut.[1]



Today's Tradition: Tegopen®

(cloxacillin sodium)

for the treatment* of known or suspected staphylococcal infections such as:

- Acute sinusitis
- Furunculosis and carbuncles
- Impetigo
- Secondarily infected dermatitis
- Cellulitis
- Abscesses
- Infected sebaceous cysts

In serious, deep-seated staph infections, 500 mg q.i.d. dosage is recommended.†

- Tegopen has been reported active against 96% of *Staphylococcus aureus*.[2]
- 80% of *S aureus* has been reported resistant to amoxicillin and ampicillin.‡[2]
- 88% of *S aureus* has been reported resistant to penicillins G and V.‡[2]
- Staph resistance to erythromycin may develop during a course of therapy.[3]



Available as 500-mg and 250-mg capsules and Oral Solution 125 mg/5 ml.

Tegopen® (cloxacillin sodium) Today's Penicillin for Today's Physician

1. Florey HW, Chain E, Heatley NG, et al: *Antibiotics*. London, Oxford University Press, 1949, p 2.
2. Bac-Data Bacteriologic Report, Professional Market Research, 1978-1979. The clinical significance of *in vitro* data is unknown.
3. Erythromycin prescribing information (in *Physicians' Desk Reference*, ed 34. Oradell, NJ, Medical Economics Co, 1980) states that staph resistance may develop during treatment.

See brief summary of prescribing information on an adjoining page.

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*Note: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin.

†In serious, life-threatening infections, oral preparations of the penicillinase-resistant penicillins should not be relied on for initial therapy

‡Not all isolates may have been tested using both discs.

Tegopen®
(cloxacillin sodium)
Capsules and Oral Solution

Brief Summary of Prescribing Information

For complete information, consult Official Package Circular (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE:

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q 6h.

Children: 50 mg./Kg./day in equally divided doses q 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

Boswell Lecturer Recalls Hellems Research



Dr. Harper Hellems, right, chairman of UMC's Department of Medicine, greets Dr. Lewis Dexter, who was the 1980 Boswell Lecturer.

Dr. Lewis Dexter, professor emeritus of medicine at Harvard, was the 1980 Boswell Lecturer at University Medical Center. During his presentation, he recalled the pioneering research of UMC medicine department chairman Dr. Harper Hellems. As a research fellow at Peter Bent Brigham Hospital on Dr. Dexter's service, Dr. Hellems devised the first successful method of measuring pulmonary capillary pressure in man.

Dr. Dexter pointed out that the work led to the development of the Swan-Ganz pulmonary artery catheter and made possible accurate monitoring of left ventricular function. The Harvard professor said the ability to measure pulmonary capillary pressure is considered critical in certain cases of acute myocardial infarction, in congestive heart failure, in any form of cardiogenic shock — and when certain intravenous medications such as sodium nitroprusside are being given.

The Boswell Lecture honors the late Dr. Henry Boswell, first and only superintendent of the Mississippi State Sanatorium. It's sponsored annually by the Mississippi Lung Association.

PLAN NOW TO ATTEND!

113th Annual Session

April 26-30, 1981

Biloxi Hilton

Code Suggests Conduct For Physicians and Attorneys

(Ed. Note: The National Interprofessional Code for Physicians and Attorneys, adopted by the American Medical Association and the American Bar Association, sets forth suggested rules of conduct for physicians and attorneys in their interrelated practice. Its purpose, as stated in the preamble, is to promote the public welfare, improve the practical working relationships of the two professions, and facilitate the administration of justice. Portions of the Code are reprinted below.)

Medical Reports

The physicians upon proper authorization should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony.

The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks.

Conferences

It is the duty of each profession to present fairly and adequately the medical information involved in legal controversies. To that end the practice of discussion in advance of the trial between the physician and the attorney is encouraged and recommended. Such discussion should be had in all instances unless it is mutually agreed that it is unnecessary.

Conferences should be held at a time and place mutually convenient to the parties. The attorney and the physician should fully disclose and discuss the medical information involved in the controversy.

Subpoena for Medical Witness

Because of conditions in a particular case or jurisdiction or because of the necessity for protecting himself or his client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process.

Arrangements for Court Appearances

While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demands upon his time. Such arrangements contemplate reasonable notice to the physician of the intention to call him as a witness and to advise him by telephone, after the trial has commenced, of the approximate time of his required attendance. The attorney should make every effort to conserve the time of the physician.

Physician Called as Witness

The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury.

It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence and credibility of a medical witness; and it is always improper and unnecessary for the attorney to embarrass or harass the physician.

Fees for Services of Physician Relative to Litigation

The physician is entitled to reasonable compensation for time spent in conferences, preparation of medical reports, and for court or other appearances. These are proper and necessary items of expense in litigation involving medical questions. The amount of the physician's fee should never be contingent upon the outcome of the case or the amount of damages awarded.

Payment of Medical Fees

The attorney should do everything possible to assure payment for services rendered by the physician for himself or his client. When the physician has not been fully paid the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive in behalf of the patient.

POSTGRADUATE CALENDAR

March 12-14, 1981
POSTGRADUATE SURGICAL FORUM VIII
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Coordinator: J. Harold Conn, M.D., professor of surgery, University of Mississippi School of Medicine and surgery division chief, Veterans Administration Medical Center.

An internationally-recognized guest faculty will join UMC faculty in presenting sessions on trauma, endocrine and breast surgery, general surgery, vascular surgery and gastrointestinal-biliary surgery. Advance registration is required. Fee: $225. Credit: 17 contact hours (1.7 CEU), Category I of the Physician's Recognition Award, AMA.

March 26-27, 1981
THIRD ANNUAL NEUROLOGY SPRING SYMPOSIUM
Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Shri K. Mishra, M.D., associate professor of neurology (part-time), University of Mississippi School of Medicine, and neurologist, Veterans Administration Medical Center.

Guest faculty for this program are Dr. John E. Bennett, chief of the Clinical Mycology Section, LCI, National Institutes of Health; Dr. Donald B. Calne, clinical director, NINCDS, National Institutes of Health; Dr. Kenneth P. Johnson, chief of neurology research, University of California at San Francisco; and Dr. Jay P. Sanford, dean of the School of Medicine, Uniform Services University of Health Sciences. Fee: $150. Credit: 13 contact hours (1.3 CEU), Category I of the Physician's Recognition Award, AMA.

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Branchitis and pneumania caused by S. pneumoniae (formerly D. pneumoniae)
Otitis media caused by S. pneumaniae (formerly D. pneumaniae) and H. influenzae
Acute exacerbation of chranic bronchitis caused by H. influenzae*
*Thaugh clinical impravement has been shown, bacteriologic cures cannat be expected in all patients with chranic respiratary disease due to H. influenzae.
SKIN AND SKIN STRUCTURES (integumentory) infectians caused by Group A beta-hemalytic streptococci and staphylococci, nonpenicillinase producers.
URINARY TRACT INFECTIONS caused by E. coli and P. mirabilis. (This drug should nat be used in any E. coli and P. mirabilis infectians other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to manitor effectiveness of therapy and susceptibility af bacterio Therapy may be instituted prior to results af sensitivity testing.
Contraindications Contraindicated in individuals with histary of an allergic reaction ta penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinicol trials demanstrated it is efficacious far recommended indications.
Serious and accosional fatal hypersensitivity (onophylactoid) reactions hove been reported in patients on penicillin. Although onophyloxis is more frequent following porenterol use, it has occurred in patients an oral penicillins. These reactions are more apt to accur in individuals with history of sensitivity to multiple allergens. There are reports of potients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalasporin. Before penicillin therapy, corefully inquire about previous hypersensitivity reactions to penicillins, cepholosporins and other allergens. If allergic reaction occurs, discontinue drug and initiote appropriate therapy. Seriaus anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use af antibiatics may pramate avergrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Categary B. Reproduction studies performed in mice and rats at dases up ta 10 times the human dase revealed na evidence af impaired fertility ar harm ta the fetus due ta cyclacillin. There are, however, na adequate and well-cantralled studies in pregnant women. Because animal repraductian studies are not always predictive af human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is nat knawn whether this drug is excreted in human milk. Because many drugs are, exercise cautian when cyclacillin is given ta a nursing waman.
Adverse Reactions Oral cyclacillin is generally well talerated. As with ather penicillins, untaward sensitivity reactions are likely, particularly in those who previously demanstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reparted with cyclacillin: diarrhea (in appraximately 1 aut af 20 patients treated), nausea and vomiting (in appraximately 1 in 50), and skin rash (in approximately 1 in 60). Isalated instonces of headache, dizziness, abdaminal pain, vaginitis, and urticaria hove been reparted. (See WARNINGS) Other less frequent odverse reactions which may accur and are reparted with ather penicillins are anemia, thrombacytopenia, thrombocytopenic purpura, leukopenio, neutropenia and eosinophilio. These reactions ore usually reversible on discontinuotion of therapy
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generolly, continue treatment at least 48 to 72 hours after patient becomes asymptomatic ar until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcol infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinicol appraisol is necessary during therapy and possibly for severol months after. Persistent infection may require treatment for severol weeks.
Cyclacillin is not indicated in children under 2 months of age.
Patients with Renol Failure Cyclacillin may be safely administered to patients with reduced renol function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require chonge in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratary Tract		
Tonsillitis & Phoryngitis	250 mg q.i.d	body weight ≤ 20 kg (44 lbs) 125 mg q.i.d body weight > 20 kg (44 lbs) 250 mg q.i.d
Bronchitis and Pneumonio		
Mild or Moderate Infections	250 mg q.i.d	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d	100 mg/kg/day q.i.d
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d †	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d	100 mg/kg/day

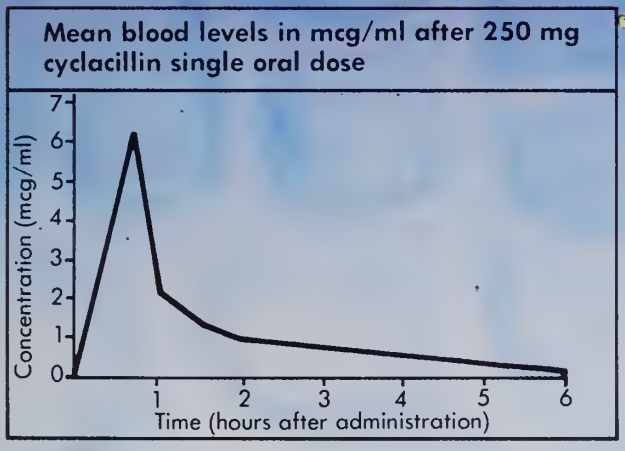
*Dosage should not result in a dose higher than that for adults.
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Half the dose is absorbed in 9 minutes!

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- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{a} ½ values for oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

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Surgeon to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

General Practice opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821.

Situations Wanted

Board eligible anesthesiologist seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

Pediatrician desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

Pediatrician completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

General Practitioner seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

Cardiologist seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

Pediatrician and Pathologist (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

Pathologist especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

Physician completing training in 1981 seeks general practice location, preferably in shortage area. Contact Kenneth K. Wheatley, Jr., M.D., 1800 Holcombe Boulevard, Apt. 205, Houston, TX 77030.

Pediatrician desires clinic or ER location in south Mississippi. Presently in training; available January 1981. Contact S. G. Eggen, M.D., 4929 Cleveland Place, Metairie, LA 70003 or call 504/837-3000 (ext. 2436 or 2395).

Pediatrician seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

Family Practitioner seeks practice location in Mississippi. Graduate of University of Washington School of Medicine, 1950. Presently practicing in Alaska. Contact Donald F. McKay, Box 631, Haines, AK 99827.

Pathologist — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

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One of America's largest health care corporations is currently seeking a full and part-time Physician for our Plasma Donor Center located in Mississippi. Responsibilities will include performing physicals in conjunction with donor screening and evaluation. The part-time position would provide support when regular staff Physicians are on vacation.

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ESTABLISHED JACKSON PHYSICIAN has office space for lease; ophthalmologist preferred; share waiting room. Contact: Lynn D. Abernethy, M.D., 653 North State St., Jackson, MS 39201; (601) 354-5385.

EQUIPMENT FOR SALE. Burdick EKG; Clay Adams Hematocrit centrifuge. Contact Dr. L. T. Carl, Jackson, MS, 366-8494 (office) or 366-3710 (home).

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IN CONCLUSION

The Office of Health Maintenance Organizations has selected the first 60 fellows to participate in its management intern program. The project director said about one-third of the fellows have prior HMO experience, one-third have health care experience in an area other than HMOs and one-third have business management experience outside of the health care field. The intern program includes eight months of training in general management, finance, marketing, information systems, and health center administration.

The Board of Trustees of the U.S. Pharmacopeial Convention has decided to continue to develop its own dispensing information system rather than implement a proposed national center for distribution of the FDA's mandatory patient package inserts. "The feeling that the mandatory PPI program may yet be stopped politically, coupled with the inherent unworkability built into the FDA system, makes the positive contributions of a national center difficult, if not hopeless, at this time," said a USP spokesman.

Physicians caring for the elderly should be especially aware of the complication of aluminum-containing antacids, says a report in the December 5 issue of JAMA. Dr. Karl L. Insogna reports the case of a 60-year-old woman with osteomalacia who had consumed big doses of antacids (some 4 ounces daily for 12 years and 12 or more ounces each day for six months prior to admission). Dr. Insogna pointed out that antacids often are used by the elderly, and poor dietary habits put these individuals at increased risk of phosphate depletion.

Four major cancer treatment centers will be included in a National Cancer Institute study of high-energy neutrons for treatment of cancer patients. The clinical trials will enroll some 8,000 patients over a ten-year period. The centers (the University of California-UCLA/VA's Wadsworth Hospital, M.D. Anderson Hospital and Tumor Institute, University of Pennsylvania/Fox Chase Cancer Center, and the University of Washington) will have the necessary equipment in place and operational by 1983.

Agricultural, forestry and nursery workers should be cautioned about handling sphagnum moss because of the risk of sporotrichosis, says Archives of Pathology and Laboratory Medicine. (Mississippi reported an outbreak involving forestry workers some years ago.).... Pet dogs were enoxerated as possible carriers of multiple sclerosis in a study reported in the January issue of Archives of Neurology....The American Academy of Pediatrics has cautioned against giving honey to infants younger than six months old because of a risk of infant botulism.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
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- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BALCONY



March 1981

Journal of the State Medical Association

Mississippi

(ISSN 0026-6396)

Contents:

Leiomyoma of the Lung:
A Case Report

Pacemakers and Scattered Radiation

Bone Involvement in Echinococcosis

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche)℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® ℞
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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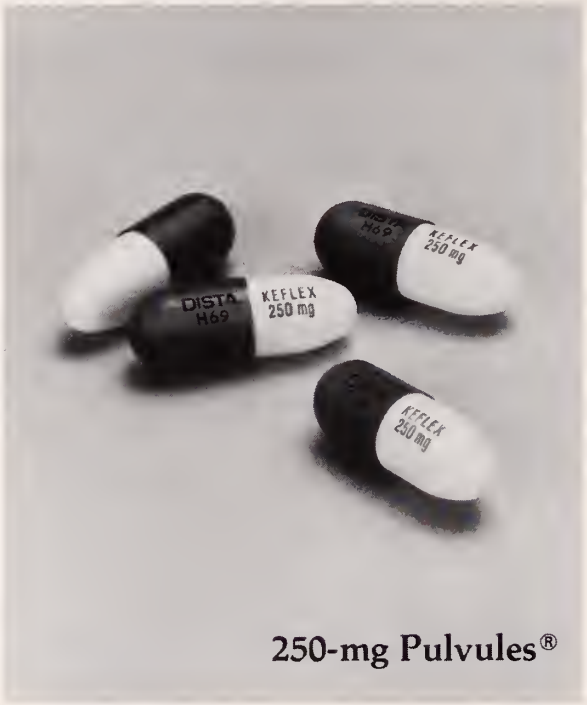
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Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.®

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS (mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

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Broad-spectrum coverage in mixed helminthic infections

TABLETS
Vermox®
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
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Committed to research...
because so much remains to be done.



Mississippi physicians participating in the 25th annual Tri-State Thoracic Conference held recently in Biloxi are (from left) Dr. Joe R. Norman, Christmas Seal Professor of Respiratory Disease at University Medical Center, Jackson; Dr. Guy D. Campbell, Mississippi Lung Association representative director to the American Lung Association Board of Directors, also of Jackson; Dr. John R. Williams, Mississippi Thoracic Society representative councilor to the American Thoracic Society, Greenville; and Dr. John R. Morgan of McComb, president of the Mississippi Thoracic Society. The conference is sponsored by Lung Associations and Thoracic Societies of Mississippi, Louisiana and Alabama.

AHA Recognizes Cost Control Effort at St. Dominic

St. Dominic-Jackson Memorial Hospital has received a Certificate of Recognition from the American Hospital Association (AHA), in acknowledgment of the hospital's efforts to more effectively monitor costs and productivity.

Sister Josephine Therese, administrator, reported that the hospital has participated in an AHA management information program to help gauge effectiveness. "The information received through this program, coupled with our own cost containment program, 'T.I.P. — Think Increased Productivity,' has enabled St. Dominic's to keep our costs to patients among the lowest in the nation," she stated.

Sister Josephine added that the latest hospital survey conducted by the Equitable Life Assurance Society of the United States showed nationwide an 82% increase in the cost of a semi-private room in the last five years; a 77% increase across Mississippi; and a 55% increase at St. Dominic Hospital.

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The basic idea of Thomas Yates & Co. hasn't changed. It's just grown. Good ideas usually do.

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NEWSLETTER

March 1981

Dear Doctor:

The AMA and 12 other defendants have successfully defended antitrust charges brought against them by five chiropractors. The unanimous decision favoring the defendants followed a 7-week trial in U.S. District Court in Chicago, and was seen as a vote of confidence in the medical profession. James H. Sammons, M.D. predicted the verdict "will have a significant impact on other cases challenging the medical profession's right to speak out on public health issues."

> The decision, which will not affect settlements agreed to last year by two former defendants, will be appealed, according to the plaintiffs' attorney. Four other lawsuits involving the medical profession and chiropractors are pending in Iowa, Pennsylvania, New York and New Jersey.

The American Hospital Association will work toward the elimination of PSROs, following action of the AHA's House of Delegates last month. The position is the same as that taken in December by the AMA House of Delegates. The AHA also expressed opposition to the health planning law, although its position on seeking the elimination of the law was not as strong at the AMA's.

Meanwhile, both the PSRO program and the health planning program were earmarked for elimination under a Reagan Administration timetable to phase them out in favor of a program encouraging competition in the health sector. Some $4 billion of the Administration's proposed $41 billion reduction in federal spending would come from cuts in HHS programs.

The Voluntary Effort urges physicians to continue to keep their fee increases well below the CPI inflation rate this year and recommends that cost effectiveness courses be included in physician education programs. In its 1981 goals statement, the VE asked hospitals to slow the rate of increase in spending to a level below last year and made specific requests of Blue Cross-Blue Shield.

Preliminary plans for MSMA's 113th Annual Session (April 26-30 in Biloxi) indicate that the meeting will be better than ever. This issue has an article outlining some of the social functions already on the schedule. More details about scientific sessions, House of Delegates, specialty society meetings and special guests will be described in the April journal.

Sincerely,

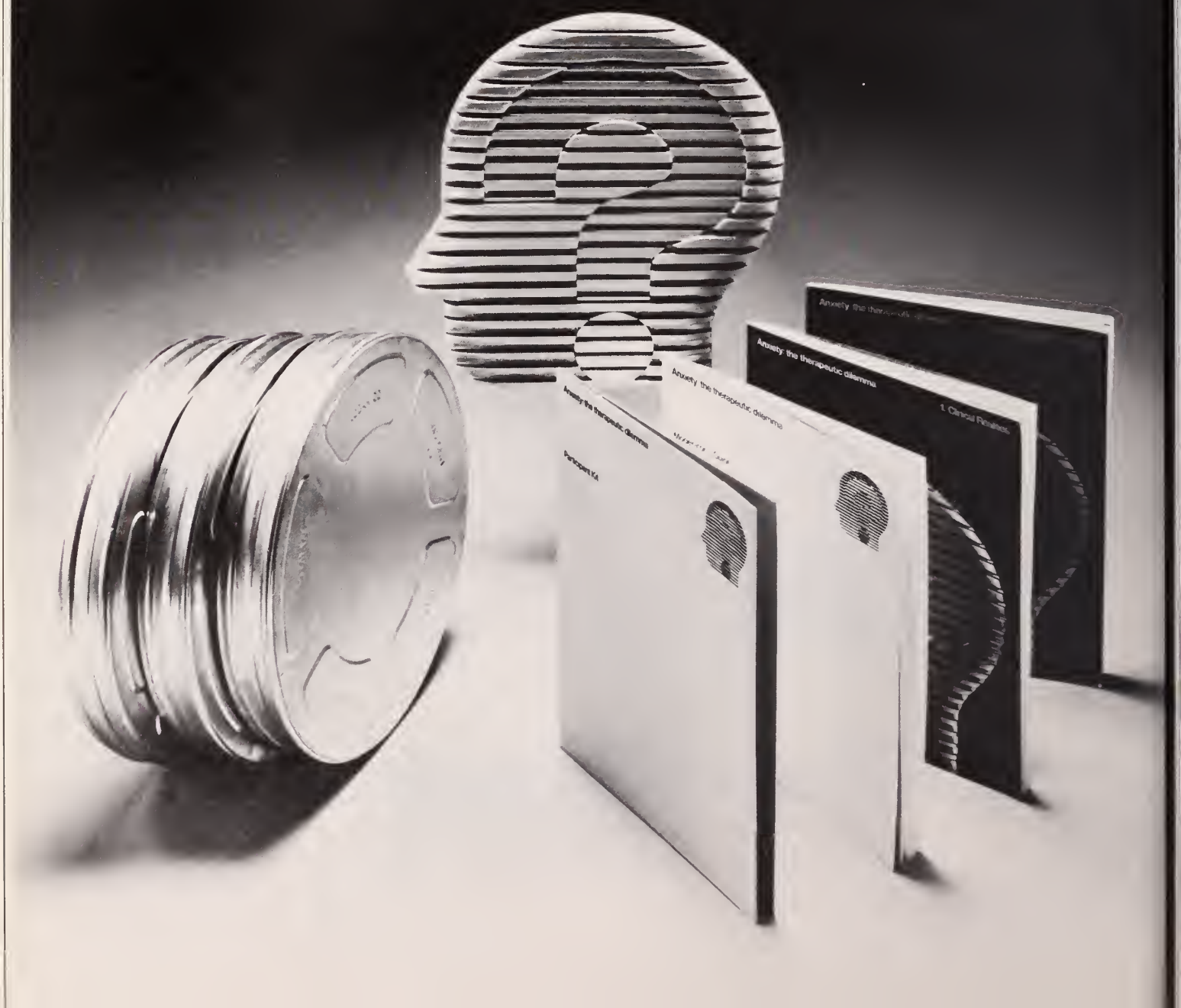
Patsy Silver

Patsy Silver
Managing Editor

Now...today's issues in anxiety management are confronted in a unique program for primary care physicians

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Ideas about anxiety management are changing. Problems have surfaced. There is concern about dependence on minor tranquilizers and new findings on receptor sites in the brain. There is a trend toward short-term therapy and interest in nondrug alternatives. Because anxiety can disable, the need to treat continues in daily practice. Primary care physicians require up-to-date information. This program can provide it.

Current Views and Opinions from Eminent Authorities

Offered free of charge, this multimedia seminar is based on a major symposium. It integrates the views of nationally known clinicians with case material to demonstrate: 1) keys to differential diagnosis, 2) recognition and management of dependence-prone patients, 3) ways to minimize tranquilizer dependency, 4) guidelines for selecting drug and nondrug therapies, 5) how the biochemistry of anxiety can affect treatment modalities. And more.

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Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



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DATELINE

Perinatal Center May Win Approval

Jackson, MS - The Mississippi Health Care Commission is expected to approve a proposal for a perinatal center at the University Medical Center. At press time, there were reports that the Commission, at its upcoming meeting, would recommend a smaller facility than the $25 million, seven-story one requested. The Commission was also expected to suggest that the perinatal center be only one part of a statewide program. MSMA favors both the proposed center and the statewide system.

Funds Loss Forces SBH Layoffs

Jackson, MS - A reduction in a federal public health grant provided by the Department of Health and Human Services has forced the Mississippi State Board of Health to slash 4% from its $28 million payroll, resulting in the layoff of 80 health department workers. The Mississippi Legislature had been asked to authorize the department to charge for health inspections it now does for free, in order to make up the lost funds, but the bill died in committee.

Greenville Jail Earns AMA Accreditation

Jackson, MS - The Greenville City Jail has been awarded two-year accreditation for its health care system. The jail, one of 17 Mississippi jails enrolled in the MSMA Jail Health Care Project, is the second in the state to achieve accreditation under AMA standards and one of only 93 in the nation currently accredited. The Copiah County Detention Center was accredited in May 1980. Chief Robert Skinner, jail supervisor Charles James, and jail physician David B. Keddy, M.D., were commended.

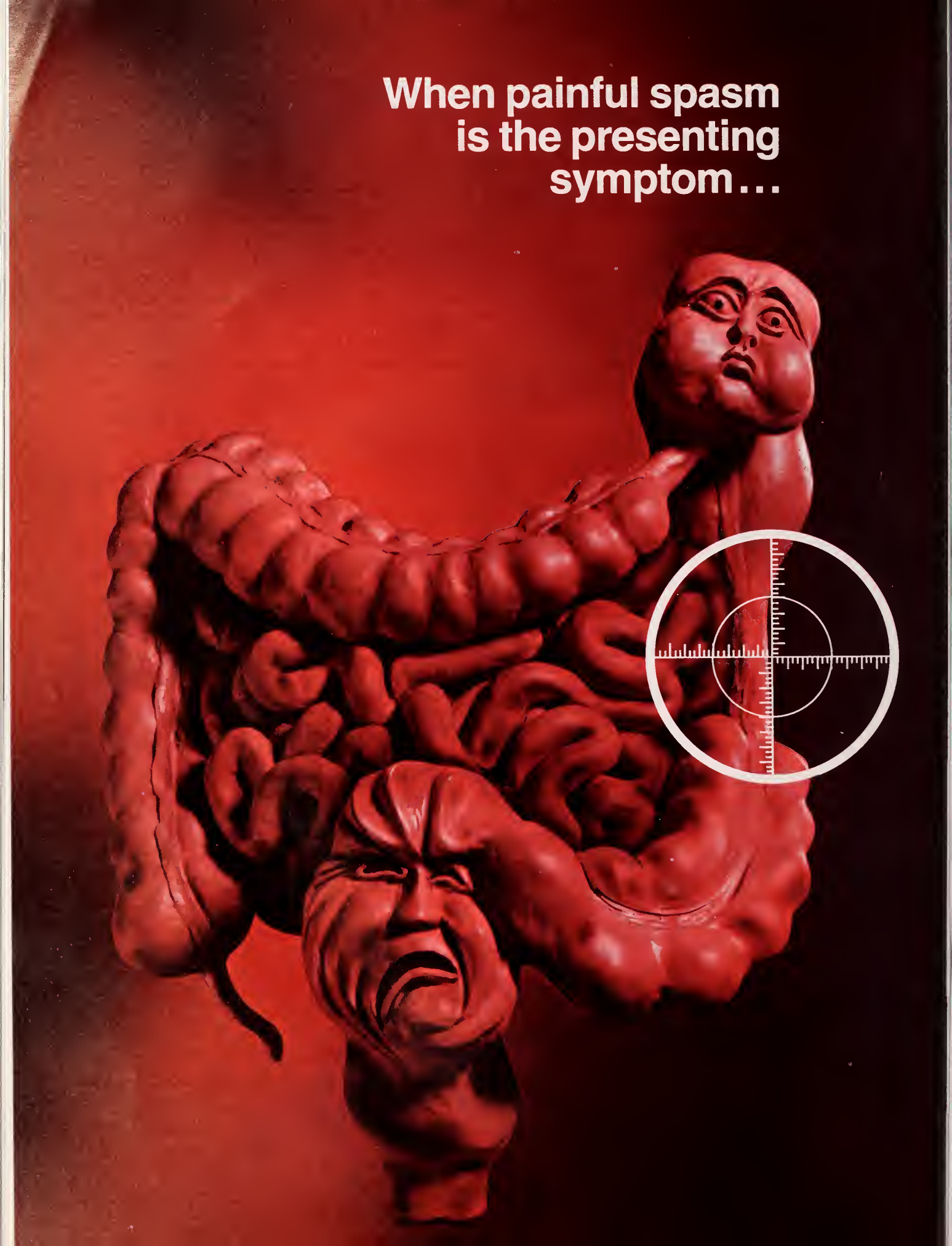
Nation May Face Rationing of Dialysis

Chicago, IL - More than 50,000 patients are being kept alive by dialysis machines, at a cost exceeding $1 billion per year. The cost probably will exceed $3 billion by 1984, says a report in JAMA. Medicare has included dialysis as a benefit since 1973. "It is yet to be decided whether rationing of medical care resources will occur by design or by default," says the author, commenting on the large numbers of patients now competing for a share of the health dollar.

Canine Cancer Called a Sentinel

Minneapolis, MN - Canine bladder cancer could be a sentinel condition which might lead to early identification of carcinogenic hazards in the general environment in certain locales, reports a research team from the National Cancer Institute. They describe studies at 13 veterinary university hospitals which found a significant correlation between canine bladder cancer and the level of industrial activity in the areas, with similar correlations found with human bladder cancer.

When painful spasm is the presenting symptom...



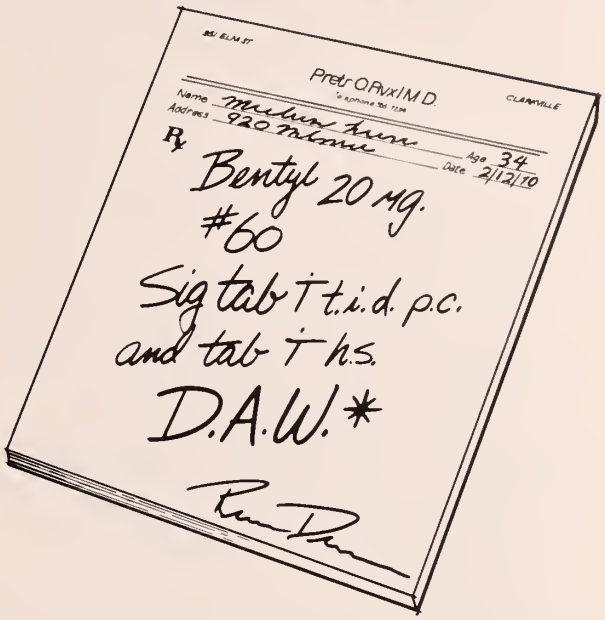
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- Pharmacologic effect in the distal colon compared to placebo†† shows how Bentyl affects abnormal motor activity in the irritable colon patient.†

† This drug has been classified "probably" effective for this indication.

Merrell

†† In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

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(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

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California Physician Lectures At University Medical Center



Dr. Nemat O. Borhani (left), professor of preventive medicine and chairman of the department at the University of California at Davis, was at the University of Mississippi Medical Center as a guest lecturer in preventive cardiology in the Department of Medicine's Division of Cardiology. With him is Dr. Richard Hutchinson, associate professor of medicine. While at UMC Dr. Borhani also presented medical grand rounds on therapy for mild hypertension.

113th Annual Session

April 26-30, 1981

Biloxi Hilton

Mark Your Calendars Now

Update on EMS Programs Will Highlight 1981 Symposium

Physicians, nurses, emergency medical technicians (EMTs), and other health care professionals will choose from a dozen different workshops for continuing education credit at the 1981 EMS Statewide Symposium.

The annual conference is scheduled for May 27-29 at the Royal d'Iberville/Best Western in Biloxi.

National EMS Director Dr. David Boyd will headline opening day activities with a national update on EMS programs. Workshop topics include care of the patient with facial injuries, environmental injuries, cardiac drugs — help or hazard?, medical management of the overdosed patient, neonatal care and transport, and trauma centers: responsibility and recognition.

The 1980 symposium drew the largest number of physicians and nurses ever, reported W. Briggs Hopson, Jr., M.D., of Vicksburg, state medical control director for the EMS Branch, Mississippi State Board of Health. Some 500 participants are expected this year, and EMS Branch director Wade Spruill, Jr., encourages physicians to register early.

Participants should send names and addresses with the $50 physician registration fee to EMS Seminars, P. O. Box 1700, Jackson, MS 39205, before May 20. Hotel reservations must be made with the Royal d'Iberville.

Joint sponsors with the EMS Branch are the Mississippi Chapters of the American College of Surgeons and the American College of Emergency Physicians and the Mississippi Affiliate, Emergency Department Nurses Association.

Affiliate sponsors are the North Mississippi EMS Authority, Southwest Mississippi EMS Authority, Southeast Mississippi Air Ambulance District, Gulf Coast EMS District, Mississippi Hospital Association, Mississippi State Medical Association, Mississippi Affiliate of the National Association of EMTs, and Mississippi Heart Association.

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Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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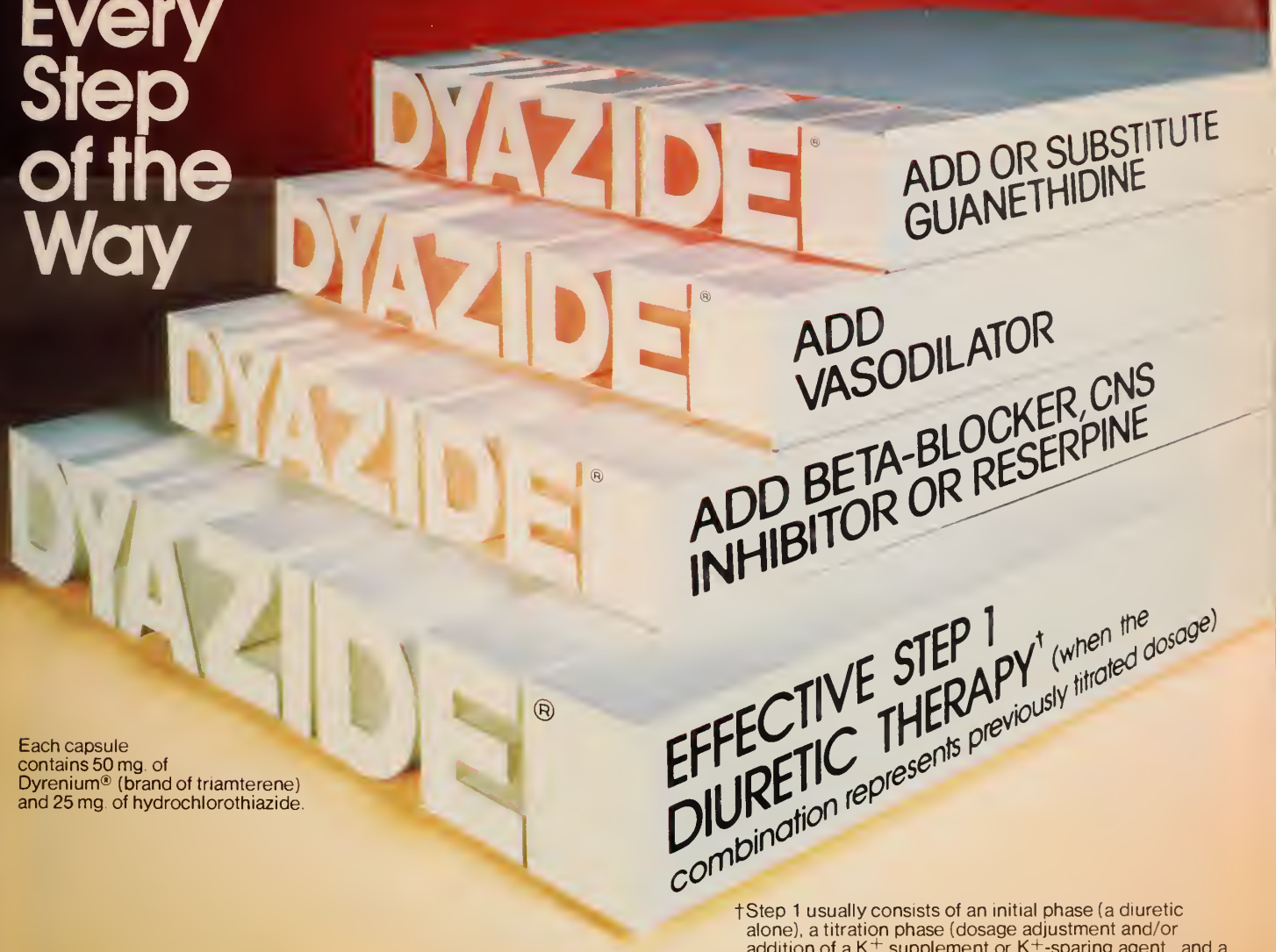
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Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

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—Thomas Edison
Inventor

There's nothing more frustrating for a scientist than to be on the verge of a great discovery and not be able to afford the equipment he needs. I know.

When I was a boy, I had to work overtime to get the money I needed for equipment. But somehow I eventually got what I had to have for my experiments.

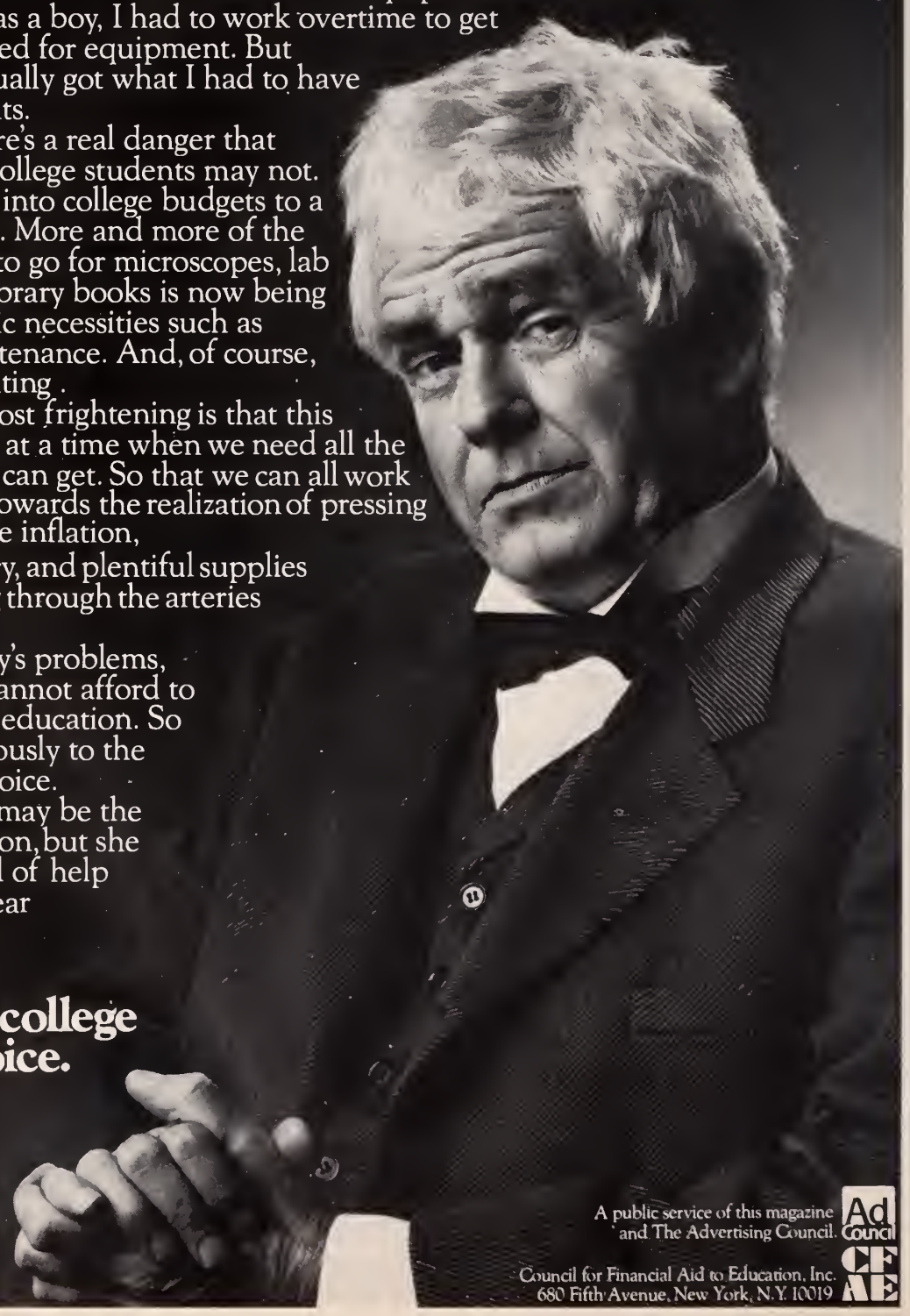
Today there's a real danger that many American college students may not. Inflation is eating into college budgets to a dangerous degree. More and more of the money that used to go for microscopes, lab equipment and library books is now being consumed by basic necessities such as heating and maintenance. And, of course, my specialty – lighting.

What is most frightening is that this squeeze is coming at a time when we need all the trained minds we can get. So that we can all work more effectively towards the realization of pressing goals: manageable inflation, revitalized industry, and plentiful supplies of energy coursing through the arteries of this country.

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ORIGINAL PAPERS

Leiomyoma of the Lung: A Case Report

W. WILSON DEFORE, Jr., M.D.,* Jackson, Mississippi and
JOSEPH I. MILLER, M.D.,† Atlanta, Georgia

LEIOMYOMA OF THE LUNG is a rare benign tumor of mesodermal origin which is often discovered incidentally on routine chest films. These have been rarely reported, and to date, only 52 cases of a leiomyoma have been recorded.[5] Because of the rarity of this lesion, a case report is presented along with a review of the literature.

Case Report

J. W., a 59-year-old white male was seen in July 1977 for evaluation of a 2.5 cm solitary lesion of the right lower lobe detected on routine chest x-ray by his physician two years previously. The patient was asymptomatic, and the only historical fact was a heavy tobacco use of 80 pack years. A review of previous chest films revealed an increase in the size of the lesion from 1 cm to 2.5 cm over the two year interval. Tomograms revealed a smooth, well demarcated lesion of the right lower lobe. The physical examination and laboratory studies were within normal limits. Bronchoscopy with brush biopsy of the right lower lobe showed no evidence of neoplasia. A right thoracotomy was performed, and a solid, well-circumscribed lesion of the right lower lobe was removed by wide wedge excision. The pathologic frozen section was reported as a benign leiomyoma of the lung (see Figure 1). The surgical procedure was completed, and the patient's postoperative course was uneventful. He has now been followed postoperatively for two years and his chest x-ray remains free of any further lesions.

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Discussion

Leiomyoma of the lung was first reported by Farkel in 1910.[4] Only 52 cases have been reported in the literature since that time.[5] The presence of a leiomyoma in the respiratory system is a very rare occurrence and ranks fourth in frequency among benign mesodermal tumors of the lung. It is preceded in frequency only by fibromas, chrondromas, and lipomas.[2] Leiomyomas comprise less than 17% of reported large series of benign primary tumors of the lung.[6]

Leiomyoma of the lung is a rare benign tumor of mesodermal origin that has been rarely reported in the world literature. The authors note that the patient is usually asymptomatic unless there is concomitant bronchial obstruction. They report that conservative resection is the treatment of choice unless extensive involvement of the pulmonary parenchyma necessitates more extensive resection.

Females are more often involved than males by a ratio of 3:2. The ages of patients reported have ranged from 6 to 67 years with the average of 35 years.

No characteristic signs or symptoms are associated with the lesion, but presenting complaints may include a cough, hemoptysis, chest pain, dyspnea, weight loss, and fever. The symptoms are most pronounced when the location of the tumor has contributed to episodes of bronchial obstruction or

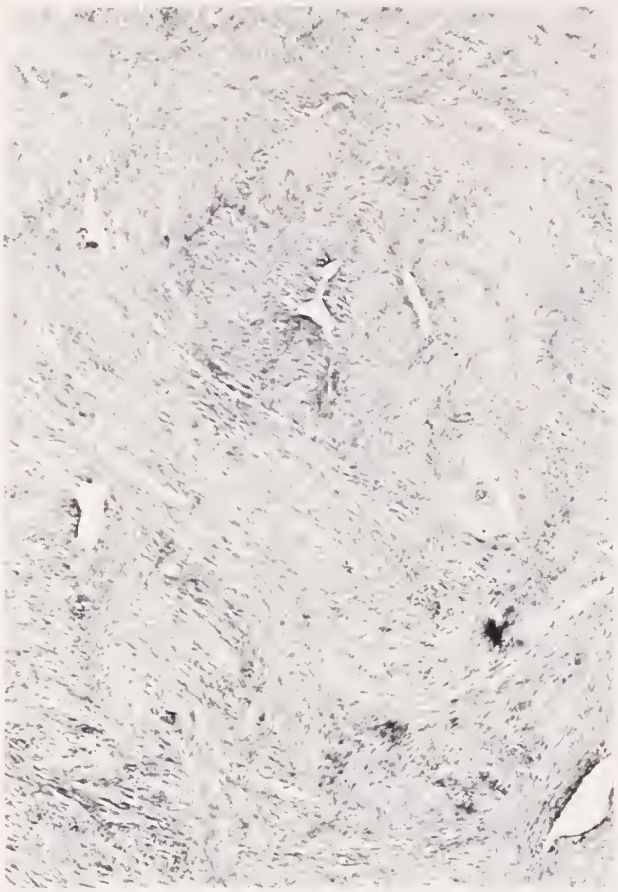


Figure 1. Microscopic section of the lung leiomyoma showing sheets of smooth muscle with white interlacing whorls of tissue, spindle-shaped in nature with varying amounts of fibrous tissue stroma.

pneumonitis. Physical findings are related to the size and location of the tumor, and examination of the patient may reveal areas of decreased breath sounds, dullness to percussion, expiratory wheezes, rhonchi, or clubbing of the extremities.

The chest film usually portrays a rounded or ovoid, well-defined mass lesion which may be associated with contiguous areas of atelectasis. There are no characteristic radiographic signs to differentiate leiomyoma from its malignant counterpart.[1] The lesions have not been noted to exhibit any predilection for either side of the chest. The x-ray of the chest is the most useful diagnostic tool and may be supplemented by tomography to identify areas of calcification, in addition to defining tumor depth and configuration.

Pathologically, leiomyoma is a primary neoplasm of muscular origin in which involvement may include the lung. Variants may include leiomyosarcoma, rhabdomyoma, and rhabdomyosarcoma. The origin is from mesenchymal tissue and may include bronchial smooth muscle, ectopic smooth muscle, or the pulmonary vasculature.

Grossly, the tumor presents a yellow-gray to white surface and is colored with a normal intact mucosa. It is firm, spherical, and often encapsulated. On cut sections, a grayish-white color in the interlacing whorls of tissue are characteristic. Microscopically, the sheets of smooth muscle predominate with white interlacing whorls of tissue, spindle-shaped in nature and occasionally mixed with flecks of calcium. The nuclei are elongated and are separated by corrective tissue septa with varying amounts of fibrous tissue stoma.[7] Neither solitary leiomyoma nor the malignant counterpart, leiomyosarcoma, bears a relationship to multiple leiomatosis of the lungs, a lesion which is similar to neurofibromatosis. To date, there are no reports of a malignant transformation of a leiomyoma.[3]

Resection of the tumor is the treatment of choice. A conservative approach is generally advocated, but the site of origin and the presence of secondary complications may necessitate a lobar or segmental resection. If the tumor is small and confined to a peripheral location and a benign nature is pathologically confirmed, a locally wide resection is adequate. However, in the presence of extensive pulmonary disease or proximal bronchial obstruction, a lobectomy or more extensive pulmonary resection may be required.[8] ★★★

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REFERENCES

1. Agnos, J. W. and Starkey, G. W. B.: Primary leiomyosarcoma and leiomyoma of the lung: Review of the literature and a report of 2 cases of leiomyosarcoma. N. Engl. J. Med. 258:12-17, 1958.
2. Arrigoni, M. G., Woolner, L. B., Berratz, P. C. et al: Benign tumors of the lung: A ten year surgical experience. J. Thorac. Carciovasc. Surg. 60:589-599, 1970.
3. Coatleman, B. and Kibbee, B.: Case records of the MGH. N. Engl. J. Med. 268:550-557, 1963.
4. Farkel, W.: Ein Fall von Fibroleiomycm der Lunge, Ztschr J. Krebsforsch 8:390, 1910.
5. Orlowski, T. M., Stasiak, K. and Kilodzie, J.: Leiomyoma of the lung. J. Thorac. Cardiovasc. Surg. 76:257-261, August, 1978.
6. Peleq, H. and Pauzher, Y.: Benign tumors of the lung. Diseases of the Chest 47:179, 1965.
7. Pierce, W. F., Alznauer, R. L. and Rolle, C.: Leiomyoma of the lung. Rach. Path. 58:443-448, 1954.
8. Taylor, T. L. and Miller, D. R.: Leiomyoma of the bronchus. J. Thorac. Cardiovasc. Surg. 57:284-288, 1969.

Pacemakers and Scattered Radiation

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Scattered radiation may be a hazard to patients with pacemakers. These patients pose particular problems to radiotherapists. Pacemakers have been irradiated in vitro, but no studies have been done regarding the effects of radiation on pacemakers during actual treatment time. The author reports the case of an irradiated patient monitored continuously during treatment. Procedures and results are described.

IMPLANTATION OF ELECTRONIC cardiac pacemakers is a routine procedure in many large hospitals.

Many patients with pacemakers also have cancer; and since ionizing radiation is used for treatment of cancer, radiotherapists are concerned about irradiating these patients.

Marbach[1] and Waiz[2] have irradiated demand-type pacemakers in vitro and found that radiation does not interfere with the working of pacemakers, though betatrons do interfere with pacemaker function. There have been no reports on the effects of scattered radiation on pacemakers in the literature.

We report a case where the effect of scattered radiation was measured by continuously monitoring the patient during actual treatment.

Case History

Mr. H. B. was a 67-year-old white male who had a left lobectomy for cancer in June 1978. In October 1979 a demand-type pacemaker (Teletronics, 160 B) was installed for sick sinus syndrome. In January 1980 the patient became short of breath and lost function in his left arm. CT scan showed multiple defects in the brain, and bronchoscopy showed complete obstruction to the left main bronchus (see Figure 1).

It was decided to treat the brain and left bronchus to open the obstruction palliatively. It was decided to give 3000 rads in ten fractions to both the left lung and the brain. We estimated that the scattered dose would be 80 rads per treatment. With the daily tumor dose at 300 rads, the total scattered dose, if the patient finished treatment, was estimated at 800 rads. This dose was calculated by checking the position of the pacemaker from the treatment field.

The patient was monitored every day of treatment by Holter Monitor (Delmar Avionics). Before starting the treatment the patient was fitted with the monitor, and the time was noted by the technician. The digital clock in the monitor was set at the same time.

During the actual treatment time, the patient was monitored continuously. The findings of EKG are described in Table 1. We started the monitor a few minutes before treatment so that we could have a base line study to compare with. The patient's pacemaker was also monitored daily after the treatment



Figure 1. Chest x-ray showing the pacemaker and treatment field.

From the Department of Radiology, University Medical Center, Jackson, MS.

by pacemaker monitor Miniclinic, which checked rate, pulse interval and pulse duration. Thus, by using daily EKGs and the pacemaker monitor, we were able to observe any change in the function of the pacemaker.

That the pacemaker was working can be seen by the fact that after the fourth treatment, the patient's blood pressure dropped suddenly during the night. An EKG was done, which showed "artificial pacemaker is firing and capturing appropriately."

After the fifth treatment the patient's condition got progressively worse. Confusion increased, and he became very short of breath. Treatment had to be discontinued. After a few days of deterioration in his condition, the patient had a severe exsanguinating hemoptysis and expired. No autopsy was done. It was assumed that the tumor had invaded a major blood vessel, causing this exsanguinating hemoptysis. According to our calculation, the pacemaker received 400 rads scattered dose during the five treatments.

Discussion

Smyth[3] cites the potential problem sources of electromagnetic radiation. The sources he stated are leaky microwave ovens,[4] active magnetometers[5] (used on weapon detectors), high energy radios, television,[6] and radar emissions from conventional and defense installations.[7]

Carleton[8] suggested that patients with pacemakers should avoid opening the hood of an automobile or approaching within three feet of a running gasoline engine. It was reported in 1964 that pacemakers appeared to be disrupted by functioning automotive distributors, spark plugs, diathermy, and cardiac defibrillators. Since then pacemakers have improved considerably.

Because of the known inhibitions of pacemakers by microwave radiation and electrical noise,[3, 4, 5, 6, 7, 8] we decided to study the effect of scattered radiation on pacemakers. Malfunction may consist of continuous or intermittent spurious signals or an interruption of normal pacer signals. Two factors are responsible for interference of pacer function — ionizing radiation and electromagnetic interference. Linear accelerators and betatrons used in radiation therapy produce electromagnetic fields that may induce noise and interference into electronic circuits.

Scattered radiation is as important as direct radiation in these patients with cardiac pacemakers. If the ionizing radiation interferes with the working mechanism of these machines, a small dose of scattered radiation would be enough to kill these patients.

This is the reason patients with pacemakers are asked not to go near microwave ovens. It is feared that even a small amount of radiation can interfere with function of these pacemakers.

Scattered radiation is important in patients with pacemakers. More patients will be exposed to scattered radiation than direct radiation to pacemaker.

Waiz irradiated in vitro five demand-type pacemakers and tested them with various radiations. The pacemaker was kept in physiological saline solution

TABLE I

Day	*Beginning Holter*	*Ending Holter*	*Total Heartbeat*	*Total VE*	*Total SVE*	*S-T Level Trend*	*Comment*
1	12:28pm	1:12pm	4256	7	2289	40	Frequent episodes of bigeminy due to PAC's. Heart rate never low enough to allow pacemaker to fire.
2	8:40am	9:05am	2845	8	137	40	Paroxysmal atrial tachycardia with ventricular rate of 140. Frequent PAC's. Heart rate never low enough to allow pacemaker to fire.
3	8:45am	9:53am	6348	—	1728	40	Frequent PAC's and occasional episodes of "PAT" lasting less than 3 seconds. Heart rate not low enough to allow pacemaker to fire.
4	8:47am	9:26am	4640	3	3130	40	Atrial flutter. Ventricular rate never low enough to allow pacemaker to fire.
5	8:36am	9:50am	1535	—	876	40	Atrial flutter with varying 2° AV block. Heart rate not low enough to allow pacemaker to fire.

and maintained at 37c to simulate normal tissue. One of the pacemakers showed changes equivalent to less than one beat per minute. This could have occurred because of a malfunction of that particular equipment. Another model of the same series did not show any untoward effect. At times some pacemakers will drop beats when the beam exciation circuits are turned on and off.

Though Waiz found no changes or only mild changes in the pacemakers after radiation, Marbach's experiment done in similar method had some disturbing results. In Marbach's experiment, pacemakers treated with betatrons failed. Marbach advises not to treat patients with pacemakers by betatron. In the case of linear accelerator, he remarks that "each case should be considered individually, since variations from one therapy unit to another can play an important role in the type of interference exerted on pacemakers."

In view of the above, we thought it would be worthwhile to see the changes during the time of radiation. We found no changes in the activity of the pacemaker during actual treatment time. ★★★

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REFERENCES

1. Marbach, J. R.: Int. J. Radiation Oncology Biol. Phys. 4:1055-1058, 1978.
2. Waiz, B., Reder, R., Pastore, J. E., Litman, P. and Johnson, R.: Cardiac pacemakers, does radiation therapy affect performance. J. Am. Med. Assoc. 234:72-73, 1975.
3. Smyth, N. P. D.: JAMA 227:1412, 1974.
4. King, et al: Effect of a microwave oven on implanted cardiac pacemaker. JAMA 212:1213, 1970.
5. Smyth, N. P. D. et al: Effect of an active magnetometer on permanently implanted pacemakers. JAMA 221:162-166, 1972.
6. D'Cunha, G. F. et al: Syncopal attacks rising from erratic demand pacemaker function in the vicinity of a television transmitter. Am. J. Cardiol. 31:789-791, 1973.
7. Mitchell, J. C., Hurt, W. D. and Walter, W. H.: Empirical studies of cardiac pacemaker interference. Read before the eighth annual meeting of the Association for the Advancement of Medical Instrumentation, Washington, D.C., March 21-23, 1973.
8. Carleton, R. A., Sessions, R. W. and Gracttinger, J. S.: Environmental influence on implantable cardiac pacemakers. JAMA 190:938-940, 1964.

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Radiologic Seminar CCXII: Bone Involvement in Echinococcosis

JAMES U. MORANO, M.D. and JUNE G. BLOUNT, M.D.
Jackson, Mississippi

ECHINOCOCCOSIS, OR HYDATID DISEASE, is caused by the tapeworm *Echinococcus*. *Echinococcus granulosus* is the species which most commonly causes hydatid disease; however, the species *E. multilocularis* may occasionally also produce the disease. The organism has world-wide distribution. Although hydatid disease is not a common occurrence in most of the continental United States, it may be seen in any region of the country when infection with the parasite is brought in from more endemic areas. Presented below is a case of echinococcosis which is unusual in that there is primary bone involvement.

Case Report

This 49-year-old black female from central Mississippi presented with a two year history of swelling over the anterior aspect of her right lower leg. This swelling grew progressively more noticeable and became painful during the month prior to her hospital admission.

The initial radiographs of her leg (see Figure 1) revealed a large cystic lesion occupying the middle one-half of the medullary portion of the tibia. The lesion appeared to encroach on the cortical portion of the bone, but no periosteal reaction was identified. There was associated soft tissue swelling about the area.

The diagnosis of *Echinococcus* cysts of the tibia was made at surgery. Curettage and packing of the lesion with bone chips was performed (see Figure 2). Further evaluation of the patient in the postoperative period failed to reveal any other sites of hydatid disease. Her social history revealed that she lived in a rural area with an abundance of dogs about her low-income house. She gave a negative travel history.

The patient did well for approximately 15 years after her initial surgery. Then she began to again develop pain and swelling about her right tibia. Radiographs at that time (see Figure 3) revealed



Figure 1. Initial films of hydatid cysts in tibia. Transverse linear lucency projecting over lower margin of cyst on the lateral view represents a film artifact.

Sponsored by the Mississippi Radiological Society. From the Department of Radiology, University Medical Center, Jackson, MS.



Figure 2. Film made during the first postoperative period after curettage and packing with bone chips.

recurrent cysts within the tibia. The patient was brought to surgery where she underwent curettage of her recurrent hydatid cysts. Her postoperative course was unremarkable.

Discussion

Passage through two different hosts, the intermediate and the definitive hosts, characterizes the life cycle of *Echinococcus*. The adult form lives in the intestine of the definitive host (dog, cat, fox). Man does not become involved in infection by the adult parasite. Ova from the adult *Echinococcus* are contained within the excreta of the definitive host, and the intermediate hosts (sheep, cattle, man) then become infected by a fecal-oral route.

Hydatid disease in man occurs when he becomes the intermediate host for the parasite. The capsule of the ingested ovum is digested, and the embryo is freed. The embryo then penetrates the intestinal wall and migrates to the liver via the portal venous system. The embryo is retained within the liver in 50% to 70% of cases; consequently, this represents the most common site of hydatid disease.[1] If the embryo manages to pass the liver blood filter, it is usually retained within the lung capillaries. The lungs, therefore, represent the second most frequent site for hydatid disease, accounting for approximately 20% to 25% of cases.[1] Infection in man by inhalation with inoculation of the bronchi has been reported to occur occasionally.



Figure 3. Recurrent hydatid cyst within same leg approximately 15 years after initial surgery.

The life cycle of *Echinococcus* is completed when scolices from the larval cystic form of the parasite within the intermediate host are ingested by the definitive host, whence they develop into the adult parasite.

The diagnosis of hydatid disease requires a high index of suspicion, particularly in areas where the disease is uncommon. A compliment fixation test and the Casoni intradermal test which utilizes hydatid cyst fluid as an antigen have been useful diagnostic aids. Eosinophilia may be present in 50% of cases.[2] The various radiographic modalities, including isotope scanning and ultrasound, may demonstrate the cystic mass lesions. Occasionally, the organism can be found in sputum, vomitus, or stool. Percutaneous aspiration of suspected hydatid cysts should never be attempted since dissemination or anaphylaxis from the highly antigenic fluid may occur.[2]

Although liver and lung are by far the most common sites for hydatid disease, it may occur in any part of the body. One frequent manner in which these rarer sites become infected is by rupture of a primary cyst with dissemination by secondary cyst formation. Primary cysts may also occur in these rare sites when the parasite bypasses the filters of the liver and lung. One manner in which this is believed to be accomplished is by passage of the parasite through anastomotic channels between the portal and main venous systems. A second method of bypassing the liver and lung involves penetration of the embryo into the intestinal lymphatics, and then into the main venous system via the thoracic duct.[1]

Hydatid disease of bone is rare, representing approximately 1% to 4% of all cases of echinococcosis.[3] Hydatid disease of bone is essentially a disease of adults with the highest incidence occurring in the 30 to 50 age range.[4] However, the bone lesions develop quite slowly, and the initial infection probably occurs during childhood.[3] All of the bone lesions in echinococcosis are due to primary cyst formation, and are not secondary to spread from other sites.[4]

Hydatid disease may affect any of the bones in the body. The spine and pelvis are commonly involved, as well as the long bones. The hydatid cysts within the bone produce slowly progressive destructive lesions which often involve a large expanse of bone. Pathological fractures frequently occur, and subsequent non-union is common.[4] When the spine is affected, both the vertebral bodies and the pedicles may become involved.[5] Spinal lesions are associated with various neurological problems secondary to rupture in the spinal canal.[4]

In contrast to bone involvement, hydatid disease of the joints is always secondary, and often due to rupture of an adjacent bone cyst.[1] Only minimal resistance to the growth of the cysts is offered by articular cartilage or intervertebral disks.[3]

Surgery is widely recommended as the treatment of choice for hydatid cysts in all locations. Regarding osseous hydatid disease, radical surgery is commonly recommended with the aim of complete removal of the parasite. However, complete removal of the organism from bone is seldom possible except in the more dispensible bones such as the fibula or a rib. Curettage and bone grafting is, therefore, the more frequently employed surgical technique, although recurrence is common. Repeat surgery for recurrent disease is recommended as often as necessary.

In conclusion, bone involvement in echinococcosis is rare. The diagnosis of hydatid disease of bone requires a high index of suspicion, and may not be made until surgery is performed. Unfortunately, the results of treatment are often not satisfactory due to the high recurrence rate. ★★★

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REFERENCES

1. Golematis, B.: Hydatid disease: History, etiology. Epidemiology, epizootiology, locations, and prevention. Surg. Ann. 10:359-86, 1978.
2. Lewis, J. W., Neal, K. and Morris, D. K.: A review of echinococcal disease. Ann. Surg. 181(4):390-6, Apr. 1975.
3. Porat, S. and Joseph, K. N.: Hydatid disease of bone: A case report and review of the literature. Isr. J. Med. Sci. 14(2):223-7, Feb. 1978.
4. Hooper, J. and McLean, I.: Hydatid disease of the femur: Report of a case. J. Bone Joint Surg. [Am] 59(7):974-6, Oct. 1977.
5. Ferrandez, H. D., Gomez-Castresanda, F., Lopaz-Duran, L., Mata, P., Brandau, D. and Sanchez-Barba, A.: Osseious hydatidosis. J. Bone Joint Surg. [Am] 60(5):685-90, July 1978.



The President Speaking

Doctors Must Issue "Smoke Alarm"

PAUL H. MOORE, M.D.
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We, as physicians, are learning more and more each year about the causes of illness and how to prevent it. We hear from day to day that medicine has just about developed to the point that further longevity of human life must come from the prevention of disease rather than treatment.

It seems to reason that if the above is true, then we must initiate and support health education in the public educational system. We read and are told that if we could abolish or diminish the big four — overeating, drug and alcohol abuse, smoking, and self-inflicted trauma (which really might primarily result from the first three) — we would have come a long way toward the prevention of illness.

As president of the MSMA and as your fellow colleague, I would like to issue a challenge to all physicians and health related personnel to abstain from smoking. We know without a shadow of doubt that there are many debilitating and fatal diseases which are directly related to the use of tobacco. We are seeing more lung cancer in the general public, and the alarming point is that it is said by the late 1980's, lung cancer in women will be the number one killer in that group. This increase is directly related to the tremendous increase in cigarette smoking by women during the past three decades. Sadly, the number one killer of women at the present time, breast cancer, is not declining.

The tobacco interest is a big one. Fortified with government subsidy and spending millions upon millions of dollars on advertising, they are convincing a large percentage of our youth that the only way to be beautiful, handsome, or sexy is to smoke "Virginia Slims" or a facsimile thereof. *We* know that this is not the case, but do *they?*

According to a 1979 study, 12% of teenagers between 12 and 18 years of age are smoking. There is a 2% higher incidence in the teenage female. This is alarming and distressing when we realize that these are our daughters and are to be the mothers of our grandchildren. I believe that the private physician can and must begin to take a very strong stand against the use of tobacco. How can we be forceful and convincing to an individual when we are sitting behind our desks puffing away? We know that it is difficult to break any habit, but as educated scientists, I believe that most of us have the self-discipline to accomplish this.

(Continued on page 60)

EDITORIALS

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MARCH 1981

Government "Cures" Produce New Ailments

A recent article in the American Journal of Law and Medicine suggests a certificate of need in an attempt to control the number of doctors. Only a few years ago a shortage of doctors was anticipated by the federal government, who, hoping to meet this shortage, pushed the medical schools to expand and increase the number of graduates. The AMA and the Association of American Medical Colleges reluctantly accepted the government's recommendation.

Now we have a "surplus" of physicians — real or imagined — and medical schools have become in large part dependent on federal funding, the loss of which may well have serious consequences. In addition there has been no better distribution of doctors, particularly in those underserved areas.

Now the Department of Labor proposes to expedite the immigration of foreign physicians to health manpower shortage areas. What is to keep them there if other areas appear more inviting after they are settled?

While big government is admittedly a necessity, its effort to finely tune the economy, to create a no-risk society, to give health instead of reasonable health care, while idealistic, is impossible to achieve, and its attempts frequently result in additional problems, sometimes nearly as serious as the original ones. The least government is the best government. Hopefully, we are beginning to see some changes in this direction.

W. Moncure Dabney, M.D.
Editor

Journal MSMA encourages your participation. Comments, inquiries and suggestions are invited.

Medico-Legal Brief

Acupuncture Clinic Closed; Practitioner Not a Physician

A Mississippi chancery judge closed a Southaven acupuncture clinic because the practitioner, George C. Reed, was not a licensed physician.

DeSoto County Chancellor L. E. Hannaford, Sr., ruled that Reed had been practicing acupuncture — medical practice under the Mississippi Code — even though he was not licensed to practice medicine. Hannaford ruled that Reed would be prohibited from further practice and would pay court costs for the case.

The ruling resulted from investigation and prosecution through the Mississippi State Board of Health, until last July the state's medical licensure agency. The legislature in its 1980 session separated medical licensure and certification into a distinct agency.

Reed had advertised his acupuncture practice as helpful in losing weight and stopping smoking. He claimed acupuncture could affect nerve deafness, arthritis, impotence, migraine headache, and back pain. His practice was located at 8710 Highway 51, Southaven.

In court proceedings, Reed admitted that he had completed only through the eighth grade and later passed the GED test. He said he was not licensed to practice medicine or any other healing art in Mississippi but that he had learned to do acupuncture through weekend seminars.

Reed, according to court records, inserted needles into a patient's body at various acupuncture points to allegedly correct an imbalance of positive and negative forces, referred to as Yin and Yang; he used charts to designate the penetration points for treating various diseases and maladies.

Chancellor Hannaford ruled that since acupuncture is a medical practice it may be legally carried out in Mississippi only by licensed medical doctors.

PRESIDENT'S PAGE / Continued

We must reach the majority of the teenagers before they start smoking; this means reaching them before they begin junior high school. Physicians have great influence with this age group, and we should use this influence during regular office visits. You, as a physician, could organize a clinic on a monthly basis and invite your teenage patients to attend.

We know that at the present time, the social climate about smoking is changing. Smoking is now banned in many public places. There are separate areas in planes, restaurants, and even in some physician offices. Smokers are even asking if it's OK to smoke. So the time is right for a big anti-smoking campaign; but how can we be forceful if we are guilty of the habit? Some say, "my patients must do as I say, not as I do." This is understandable and may work in some cases, but to be really effective, we must practice what we preach.

We do not want to cause physical confrontation between smokers and nonsmokers. We merely are advocating a way that we, as physicians, can not only prolong the lives of our patients, but our own lives as well. *After all, is that not what medicine is all about?*

Don't forget to make your reservations for the MSMA Annual Session on the beautiful Mississippi Gulf Coast!

MSMA President Addresses Central Medical Society



Dr. Paul H. Moore of Pascagoula, left, president of MSMA, was guest speaker at a recent meeting of Central Medical Society. He was welcomed by society president Dr. Curtis Roberts of Brandon, right. Dr. Moore discussed the role of the physician in today's society and stressed the accomplishments of organized medicine.

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by S. pneumoniae (formerly *D. pneumoniae*)
Otitis media caused by S. pneumoniae (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.
Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.
Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d
Otitis Media	250 mg to 500 mg q.i.d †	50 to 100 mg/kg/day†
Skin & Skin *Structures*	250 mg to 500 mg q.i.d †	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults
†depending on severity

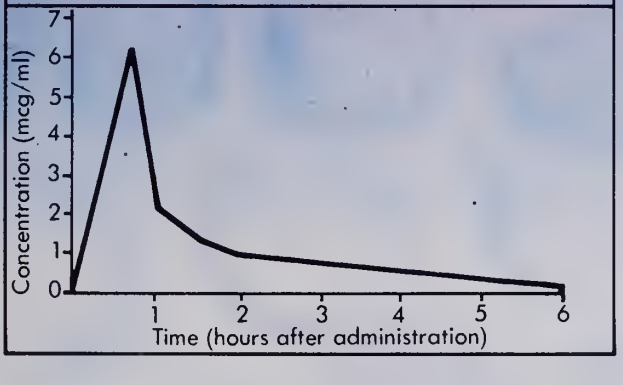
Wyeth Laboratories
Philadelphia, Pa 19101

Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{α} ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W

(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW NAME

Wyeth Laboratories · Philadelphia, Pa 19101

PRACTICE MANAGEMENT MAILBOX

Closing a Medical Practice Requires Special Actions

Because of the unique relationship between a doctor and his patients, closing an office practice is not as easy as locking the door and walking away. Among the most important considerations, if not *the* most important, is informing your patients and making sure that copies of their medical records are made available to other physicians so the treatment of your patients will not be interrupted. The notice may be by newspaper announcement or preferably by letter, especially to active patients.

In addition to notifying your patients, you should also notify other groups. These include the Mississippi State Board of Medical Licensure, your specialty society, Mississippi State Medical Association, and the American Medical Association. (Even if you are not an AMA member, the AMA maintains *the* national registry of all physicians.) You should also notify the U. S. Drug Enforcement Agency so that your Controlled Substances Registration Certificate can be voided.

You will also be faced with the problem of disposition of medical supplies and drugs. It is a good idea to check with other physicians in the area as a means of disposing of these items.

Although you may dispose of some things, others *must* be kept. You must retain your medical records. It is best to keep them indefinitely; and if space becomes a problem in storing the records, consider having them microfilmed for compact storage.

It is also important to make efforts to collect fees at the time of service during the last few months of your active practice since the receipt of accounts receivable decreases rapidly once your front door is locked. Accounts receivable should probably be turned over to a collection agency or attorney for collection soon after your office closes. Arrangements should be made with insurance companies for handling claim forms that might come in after the practice has closed.

Cancellation of business insurance as well as liability insurance should be attended to. Additional considerations are closing business bank accounts, disposing of office furnishings, cancellation of subscriptions, and termination of phone and utilities.

This is not an exhaustive checklist of measures that must be taken in closing a practice, and space does not lend itself to a full discussion of these considerations. For additional information, always feel free to contact the Mississippi State Medical Association. — B.C.M.

(Ed. Note: Please address your practice management inquiries to Bucky Murphy, P. O. Box 5229, Jackson, MS 39216.)

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MSMA's Big 113th Annual Session Offers Something for Everyone

It won't be all work and no play at MSMA's big 113th Annual Session, April 26-30 in Biloxi. In addition to the several scientific programs scheduled each day of the meeting, there will be many sports and social activities and an art exhibit.

Social activities will kick off with the President's reception for all MSMA members and their spouses on Sunday evening, April 26.

MSMA members and their spouses have been invited to show their paintings at the exhibit beginning Sunday, April 26 and running through the entire annual session. Judi Betts, well known artist and teacher from Baton Rouge, will judge the art show.

Ole Miss and Tennessee Medical Alumni both will hold social events on Monday evening, April 27. The Ole Miss activities will include a seafood jamboree and will be held at the Royal d'Iberville in the hotel's spacious Versailles Room overlooking the Gulf.

Golf and Tennis Tournments will be conducted on Tuesday, April 28. This year an added sports attraction will be a deep sea fishing tournament. The fishing tournament will be held on both Tuesday and Wednesday, and the Coast's top charter boats have been reserved for the event.

On Tuesday evening, LSU and Tulane Medical Alumni will hold social events. This will be the first gathering of LSU Alumni at an MSMA Annual Session.

On Wednesday evening, April 29, MSMA will hold its annual membership banquet. This year's event will again feature a national speaker.

The scientific program for the five-day session will include programs scheduled by MSMA's 14 scientific sections on Sunday, Tuesday and Wednesday. Highlighting the Section on Family Practice program on Wednesday morning will be the First Annual James Grant Thompson Memorial Lecture, to be delivered by Dr. Gerald Weissmann, M.D., professor of medicine at New York University School of Medicine.

The House of Delegates will hold sessions on Monday, April 27, and Thursday, April 30.

Numerous specialty societies will conduct business meetings and social functions during the week.

The MSMA Auxiliary will hold its annual session on Tuesday, April 28. In addition to the regular business meeting, the Auxiliary will have a luncheon and fashion show. On Wednesday, April 29, the Auxiliary will present a special program on beauty, diet and exercise, conducted by representatives of the "Greenhouse," a luxurious health and beauty resort located in Arlington, TX.

The Biloxi Hilton will serve as convention hotel for the 113th Annual Session. The complete program will be published in the upcoming April issue of JOURNAL MSMA.



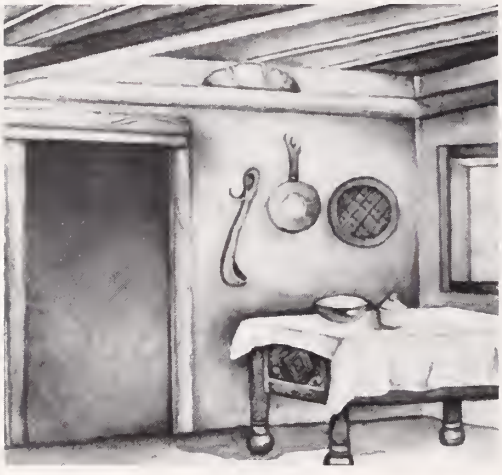
Tennis
Deep Sea Fishing
Golf

These tournaments are just a few of the special activities on the schedule for MSMA's 113th Annual Session.

Plan Now To Attend!

Yesterday's Folk Remedy:

A rye loaf in the rafters.



Early in this century in Central Europe, almost every farm family kept a loaf of moldy rye bread on one of the kitchen beams. When any family member was cut or bruised, it was an old custom to cut a thin slice from the outside of the loaf, mix it into a paste with water, and apply it to the wound with a bandage. It was believed that no infection would then result from the cut.[1]



Today's Tradition: Tegopen®

(cloxacillin sodium)

for the treatment* of known or suspected staphylococcal infections such as:

- Acute sinusitis
- Furunculosis and carbuncles
- Impetigo
- Secondarily infected dermatitis
- Cellulitis
- Abscesses
- Infected sebaceous cysts

In serious, deep-seated staph infections, 500 mg q.i.d. dosage is recommended.†

- Tegopen has been reported active against 96% of *Staphylococcus aureus*.[2]
- 80% of *S aureus* has been reported resistant to amoxicillin and ampicillin.‡[2]
- 88% of *S aureus* has been reported resistant to penicillins G and V.‡[2]
- Staph resistance to erythromycin may develop during a course of therapy.[3]



Available as 500-mg and 250-mg capsules and Oral Solution 125 mg/5 ml.

Tegopen® (cloxacillin sodium) Today's Penicillin for Today's Physician

1. Florey HW, Chain E, Heatley NG, et al: *Antibiotics*. London, Oxford University Press, 1949, p 2.
2. Bac-Data Bacteriologic Report, Professional Market Research, 1978-1979. The clinical significance of *in vitro* data is unknown.
3. Erythromycin prescribing information (in *Physicians' Desk Reference*, ed 34. Oradell, NJ, Medical Economics Co, 1980) states that staph resistance may develop during treatment

See brief summary of prescribing information on an adjoining page.

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*Note: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin

†In serious, life-threatening infections, oral preparations of the penicillinase-resistant penicillins should not be relied on for initial therapy.

‡Not all isolates may have been tested using both discs

Tegopen®
(cloxacillin sodium)
Capsules and Oral Solution

Brief Summary of Prescribing Information
For complete information, consult Official Package Circular
(12) 9/11/75

INDICATIONS:
Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)
Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE
When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.
Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.
Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.
Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:
A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.
There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.
Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.
As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.
Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.
N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles

BRISTOL®
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POSTGRADUATE CALENDAR

March 12-14, 1981
POSTGRADUATE SURGICAL FORUM VIII
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Coordinator: J. Harold Conn, M.D., professor of surgery, University of Mississippi School of Medicine and surgery division chief, Veterans Administration Medical Center.

An internationally-recognized guest faculty will join UMC faculty in presenting sessions on trauma, endocrine and breast surgery, general surgery, vascular surgery and gastrointestinal-biliary surgery. Advance registration is required. Fee: $225. Credit: 17 contact hours (1.7 CEU), Category I of the Physician's Recognition Award, AMA.

March 26-27, 1981
THIRD ANNUAL NEUROLOGY SPRING SYMPOSIUM
Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Shri K. Mishra, M.D., associate professor of neurology (part-time), University of Mississippi School of Medicine, and neurologist, Veterans Administration Medical Center.

Guest faculty for this program are Dr. John E. Bennett, chief of the Clinical Mycology Section, LCI, National Institutes of Health; Dr. Donald B. Calne, clinical director, NINCDS, National Institutes of Health; Dr. Kenneth P. Johnson, chief of neurology research, University of California at San Francisco; and Dr. Jay P. Sanford, dean of the School of Medicine, Uniform Services University of Health Sciences. Fee: $150. Credit: 13 contact hours (1.3 CEU), Category I of the Physician's Recognition Award, AMA.

April 21-22, 1981
HEMATOLOGY UPDATE: NEOPLASTIC DISORDERS
University Medical Center, Jackson

Sponsors are the University of Mississippi School of Medicine Department of Medicine Division of Hematology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Francis S. Morrison, M.D., professor of medicine and director of the division of hematology, University of Mississippi School of Medicine.

This program is designed for primary care physicians and will provide practical information on the modern approach to management and supportive care of patients with hematologic neoplastic disorders. Emphasis is on recent advances in management of leukemia and lymphoma which have resulted in a higher rate of cure. Fee: $40. Credit: 6.5 credit hours (.65 CEU), Category I of the Physician's Recognition Award, AMA.



Tri-State Geriatric Seminar

Mobile, Alabama, March 27, 1981
Management of Day to Day Problems of Aging

Under the joint sponsorship of Ochsner Clinic, Tulane School of Medicine, Louisiana State University School of Medicine, the University of Mississippi College of Medicine, and the University of South Alabama College of Medicine

Before the year 2000 there will be a doubling and possibly redoubling of the number of elderly Americans. Too often there is little recognition by attending physicians that the presentation of illness and therapy differ greatly in the older patient.

Seminar speakers have developed expertise in the clinical problems associated with the elderly. Experts from Southern medical schools and from outside the region will lead discussions in their areas of expertise.

The Geriatric Seminar will be held at the University of South Alabama Brookley Center, located on renowned Mobile Bay. The Center is ideally located only minutes away from downtown Mobile and easily accessible to major highways and the Municipal Airport. Airport facility for private planes adjacent to the Center. Accommodations, suites in two lodges at conference site. Golf, bowling, swimming, jogging, tennis, etc.

A dinner the night before the daylong seminar will open the program, with all registrants and lecturers in attendance.

Registration: $95.

CME: Eight credits toward the Physician's Recognition Award.

Contact: University of South Alabama College of Medicine, Office of Continuing Medical Education, 2451 Fillingim St., Mobile, AL 36617. Phone (205) 476-3752.

May 2-3, 1981
CLINICAL NUCLEAR MEDICINE IMAGING
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Radiology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: C. Jay Kees, III, M.D., clinical instructor in radiology. University of Mississippi School of Medicine.

This program will include sessions on application of nuclear medicine in abdominal disease and procedures in oncology, nuclear medicine brain imaging in the era of CT and thyroid diagnosis and treatment. Fee: $50 for physicians and scientist members of the Mississippi Society of Nuclear Medicine ($60 for nonmembers). Credit: 8 contact hours (.8 CEU), Category I of the Physician's Recognition Award, AMA.

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

Southern Regional Conference on Emergency and Critical Care Medicine

May 20-22, 1981
Huntsville Hilton/Von Braun Civic Center
Huntsville, AL

This conference will provide the emergency department and primary care physician with an in-depth discussion and thorough review of major problems associated with the multi-system injured patient. The presentations will focus on initial assessment and contemporary treatment modalities with a special session addressing legal vulnerability in the clinical setting. Lectures are supplemented by clinical case presentations to illustrate approaches to commonly encountered problems. A distinguished guest faculty is participating in the seminar and a comprehensive written course syllabus will be provided. The program is sponsored by the North Alabama Emergency Medical Services agency and co-hosted by the University of Alabama School of Medicine, Huntsville Program, the Alabama Chapter of the American College of Emergency Physicians, the American Trauma Society and the Alabama Committee on Trauma. The program has been approved by the AMA, AAFP and ACEP for 18 hours Category I credit. For further information, contact Mr. Steven Hall, Administrator, North Alabama EMS, Inc., Box 2104, Decatur, AK 35602; (205) 353-3800.

PERSONALS

ROGER T. ATTERBERRY announces the opening of his family practice office at 505 LaRosa in Long Beach.

WILLIAM E. BOWLUS, JAMES L. CROSTHWAIT, C. E. FARMER, B. G. SPELL, WILLIAM B. THOMPSON, and RICHARD L. YELVERTON, all of Jackson, were speakers for a sports medicine clinic sponsored by the Governor's Council on Physical Fitness and Sports and the Mississippi Association of Coaches.

WILLIAM BRADFORD of Pascagoula and ROBERT LOWE of Jackson were among speakers for a workshop on shock held in Biloxi and sponsored by the Mississippi Gulf Coast Chapter of the National Emergency Department Nurse Association.

JOHN L. BROCKMANN announces the opening of his offices for the practice of general, thoracic and colon and rectal surgery at Suite 106, Physician's Office Building, Grenada.

JOE BURNETT of Oxford has been appointed by Gov. William Winter to a three-year term on the State Council of Advisers in Speech Pathology and Audiology.

Neuropsychiatry and Psychology Associates (WILLIAM H. C. DUDLEY and REGINALD P. WHITE) have opened offices at Meridian Regional Hospital in Meridian.

THOMAS H. GANDY of Natchez was guest speaker for the fourth annual membership meeting of the Historic Natchez Foundation.

WILLIAM H. GULLUNG, III of Hattiesburg has been named a fellow of the American Academy of Dermatology and a diplomate of the American Board of Dermatology.

VALEE HARISDANGKUL of Jackson has been elected a fellow in the American College of Physicians.

JAMES HARDY of UMC was guest lecturer in a recent program in Shreveport sponsored by Louisiana State University and the Shreveport Surgical Society.

CHARLES M. HOLMAN of Biloxi has been elected chief of staff at Howard Memorial Hospital.

JOHN JACKSON of UMC presented a paper at the Southern Society for Clinical Investigation in New Orleans in January.

JAMES H. JOHNSTON of Jackson was on the faculty of a postgraduate conference on therapeutic gastrointestinal laser endoscopy held recently in San Francisco.

K. N. MANIKTAHLA announces the opening of his office for the practice of urology at Norfleet Medical Building, Senatobia.

S. H. MCDONNIEAL and WILLIAM F. SISTRUNK of Jackson have been appointed by Gov. William Winter to the board of trustees of the Mississippi Crippled Children's Center.

MICHAEL T. NICHOLSON has associated with Rush Medical Group, 1730 14th Street, Meridian, for the practice of family medicine.

EDWIN R. NORRIS announces the opening of his office for the practice of family medicine at 101 Bank Street in Union.

ROBERT O'NEAL of UMC was a site visitor in Winston-Salem, NC, for the National Heart, Lung and Blood Institute in January.

J. J. PITTMAN of Tylertown was honored by Walthall County General Hospital for his years of service to the hospital and the community.

ONEY C. RAINES, III of Gulfport has associated with Woman's Clinic, P.A., 1213 Broad Avenue, for the continuing practice of obstetrics and gynecology.

WILLIAM B. ROBINSON announces the relocation of his office for the practice of adult psychiatry to 609 Washington Avenue in Ocean Springs.

WENDELL STOCKTON of Amory has been appointed by Gov. William Winter to a four-year term as medical representative with the newly created Governor's Commission for Children and Youth.

W. LAMAR WEEMS of Jackson has returned to the staff of UMC after a six-month leave of absence in Columbus.

WILLIAM E. WEEMS and CECIL T. WILLIAMS, JR. announce the opening of the Laurel Heart Clinic (adult cardiology and internal medicine), with offices located at 227 South 13th Avenue in Laurel.

JOHN J. TOOHIG announces the opening of his office for family practice in the Doctor's Office Annex, North Panola Regional Hospital and Nursing Center, Sardis.

NEW MEMBERS

BILLINGTON, WILLIAM M., West Point. Born Clovis, NM, Jan. 25, 1947; D.O., Kansas City College of Osteopathic Medicine, 1978; elected by Prairie Medical Society.

BRITT, ALBERT WAYNE, Jackson. Born Durango, CO, Apr. 24, 1944; M.D., Louisiana State University School of Medicine, New Orleans, 1970; interned LSU Medical Center, Shreveport, one year; radiology residency, same, 1973-74; radiology residency, University of Arkansas Medical Center, Little Rock, 1974-76; elected by Central Medical Society.

BUSH, CHARLES CRAWLEY, JR., Jackson. Born Natchez, MS, Aug. 15, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned UMC, Jackson; ob-gyn residency, same, 1976-80; elected by Central Medical Society.

CARNER, DAVID VANCE, Brookhaven. Born Basim, India, Feb. 1, 1949; M.D., Tulane University School of Medicine, New Orleans, 1974; interned UMC, Jackson, MS, 1974-75; general surgery residency, same, 1975-79; fellowship peripheral vascular surgery, LSU, New Orleans, 1979-80; elected by South Central Medical Society.

CAVETT, CLINTON MOORE, Jackson. Born Jackson, MS, Aug. 8, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Parkland Memorial Hospital, Dallas, 1973-74; general surgery residency, UMC, Jackson, 1974-78; pediatric surgery residency, Childrens Hospital, Washington, DC, 1978-80; elected by Central Medical Society.

CODE, REDMOND L., Born Mobile, AL, Oct. 4, 1943; M.D., University of Tennessee College of Medicine, Memphis, 1971; interned Los Angeles County General Hospital, Los Angeles, 1971-72; elected by DeSoto County Medical Society.

CORLEY, FRED GOODWIN, Oxford. Born McComb, MS, May 30, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned University of Texas, Parkland Hospital, Dallas, one year; orthopedic surgery residency, University of Texas, San Antonio, 1974-78; University Edinburgh, Scotland, 1978-79; elected by North Mississippi Medical Society.

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
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Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
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Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
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NEW MEMBERS / Continued

EGGEN, STEVEN DOUGLAS, Centerville. Born Chicago, IL, Sept. 17, 1954; M.D., Louisiana State University School of Medicine, New Orleans, 1979; interned Ochsner Foundation Hospital, New Orleans, one year; elected by Amite-Wilkinson County Medical Society.

HARPER, WILLIAM KENNETH, Jackson. Born McComb, MS, July 10, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned William Beaumont Army Medical Center, El Paso, TX, 1973-74; internal medicine residency, same, 1973-76; fellowship cardiovascular disease, Walter Reed, Washington, DC, 1976-78; elected by Central Medical Society.

HARRISON, ROBERT BRENT, Jackson. Born Greer, SC, March 17, 1938; M.D., Duke University School of Medicine, Durham, NC, 1961; interned St. Anthony Hospital, Denver, CO, one year; radiology residency, Norfolk General Hospital, Norfolk, VA, 1966-69; radiology residency, University of Virginia, Charlottesville, 1969-70; elected by Central Medical Society.

HAYDEN, FRANKLIN ROSS, Poplarville. Born Washington, DC, Jan. 27, 1930; M.D., University of Maryland School of Medicine, Baltimore, 1960; interned Duval Medical Center, Jacksonville, FL, one year; internal medicine residency, Beckley Memorial Hospital, WV, 1962-63; internal medicine residency, V. A. Hospital, New Orleans, 1969; elected by Pearl River Medical Society.

HICKS, GILLIAM SWINK, JR., Jackson. Born Natchez, MS, Feb. 24, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned UMC, Jackson, one year; internal medicine residency, same, 1976-78; elected by Central Medical Society.

HOUSTON, THOMAS PRICE, Jackson. Born Starkville, MS, Aug. 27, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and family practice residency, UMC, Jackson, 1977-80; elected by Central Medical Society.

HULETT, WILLIAM B., Jackson. Born New Orleans, LA, Dec. 4, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Mobile General Hospital, Mobile, AL, 1973-74; anesthesiology residency, UMC, Jackson, 1974-76; elected by Central Medical Society.

JACOB, RUDOLPH DANIEL, Pass Christian. Born Great Lakes, IL, Feb. 16, 1949; M.D., Tulane University School of Medicine, New Orleans, 1974; interned and ob-gyn residency, same, 1974-76; elected by Coast Counties Medical Society.

JEFFCOAT CAMILLE JOHNSON, Columbus. Born Jackson, MS, Sept. 26, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and anesthesiology residency, UMC, Jackson, 1977-80; elected by Prairie Medical Society.

JONES, W. ARTHUR, Jackson. Born Morton, MS, Feb. 8, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned St. Paul Hospital, Dallas, one year, medicine residency, UMC, Jackson, 1969-71; cardiology residency, St. Paul's Hospital, Dallas, 1972-73; cardiology residency, UMC, Jackson, 1971-72; elected by Central Medical Society.

KRUEGER, RONALD PAUL, Jackson. Born Newark, NJ, May 18, 1935; M.D., Duke University School of Medicine, Durham, NC, 1965; interned Duke Medical Center, Durham, one year; pediatric residency, same, 1966-67; nephrology residency, same, 1967-70; urology residency, same, 1976-79; elected by Central Medical Society.

MASON GILBERT RUTLEDGE, Biloxi. Born Jackson, MS, Oct. 7, 1928; M.D., Howard University College of Medicine, Washington, DC, 1954; interned Homer G. Phillips Hospital, St. Louis, MO, one year; elected by Coast Counties Medical Society.

MCMULLAN, GEORGE KNOX, JR., Jackson. Born Washington, DC, June 20, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned Letterman Army Medical Center, San Francisco, one year; medicine residency, Brooke Army Hospital, Ft. Sam Houston, San Antonio, 1969-73; fellowship in cardiology, Harvard Army Hospital, West Roxbury, VA, 1974-76; elected by Central Medical Society.

MEGEHEE, JAMES ALFRED, Hattiesburg. Born Oxford, MS, Aug. 6, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned Mobile General Hospital, Mobile, AL, 1968-69; general surgery residency, UMC, Jackson, 1969-70; pathology residency, Tulane, New Orleans, 1977-80; elected by South Mississippi Medical Society.

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NEW MEMBERS / Continued

MILAM, JOHN BENJAMIN, Jackson. Born Bay Springs, MS, Sept. 7, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Baptist Memorial Hospital, Memphis, one year; ophthalmology residency, UMC, Jackson, 1975-78; fellowship pediatric ophthalmology, Baylor College of Medicine, Houston, 1978-79; fellowship corneal and external diseases, same, 1979-80; elected by Central Medical Society.

NORMAN, PATRICIA H., Jackson. Born New Orleans, LA, Aug. 2, 1930; M.D., Medical College of Alabama, Birmingham, 1956; interned University Hospital, Birmingham, one year; anesthesiology residency, same, 1957-59; elected by Central Medical Society.

NORTHEY, DAN RAYMOND, Hattiesburg. Born Tulsa, OK, June 21, 1948; M.D., University of Oklahoma School of Medicine, Oklahoma City, 1974; interned St. Anthony Hospital, Oklahoma City, one year; medicine residency, same, 1975-78; fellowship gastroenterology, same, 1978-80; elected by South Mississippi Medical Society.

RODRIGUEZ, REYNALDO, Jackson. Born Laredo, TX, Aug. 14, 1945; M.D., Baylor College of Medicine, Houston, 1977; interned Baylor Hospital, Houston, one year; anesthesiology residency, UMC, Jackson, 1977-80; elected by Central Medical Society.

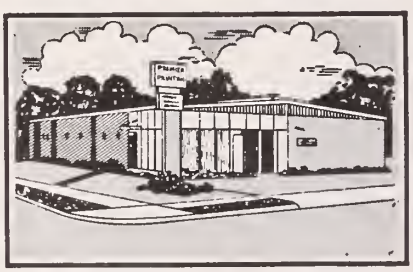
STRIBLING, JOSEPH GORDON, Brandon. Born Oxford, MS, Jan. 20, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned University of Alabama, Birmingham, 1974-75; surgery residency, UMC, Jackson, 1975-77; elected by Central Medical Society.

SUDDUTH, EDWIN P., Jackson. Born West Point, MS, Sept. 21, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and medicine residency, UMC, Jackson, 1977-80; elected by Central Medical Society.

VAUGHAN, WILLIAM HUTCHERSON, JR., Pascagoula. Born Jackson, MS, May 17, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Willford Hall, USAF Hospital, one year; psychiatry and neurology residency, Tulane University, New Orleans, 1971-74; elected by Singing River Medical Society.

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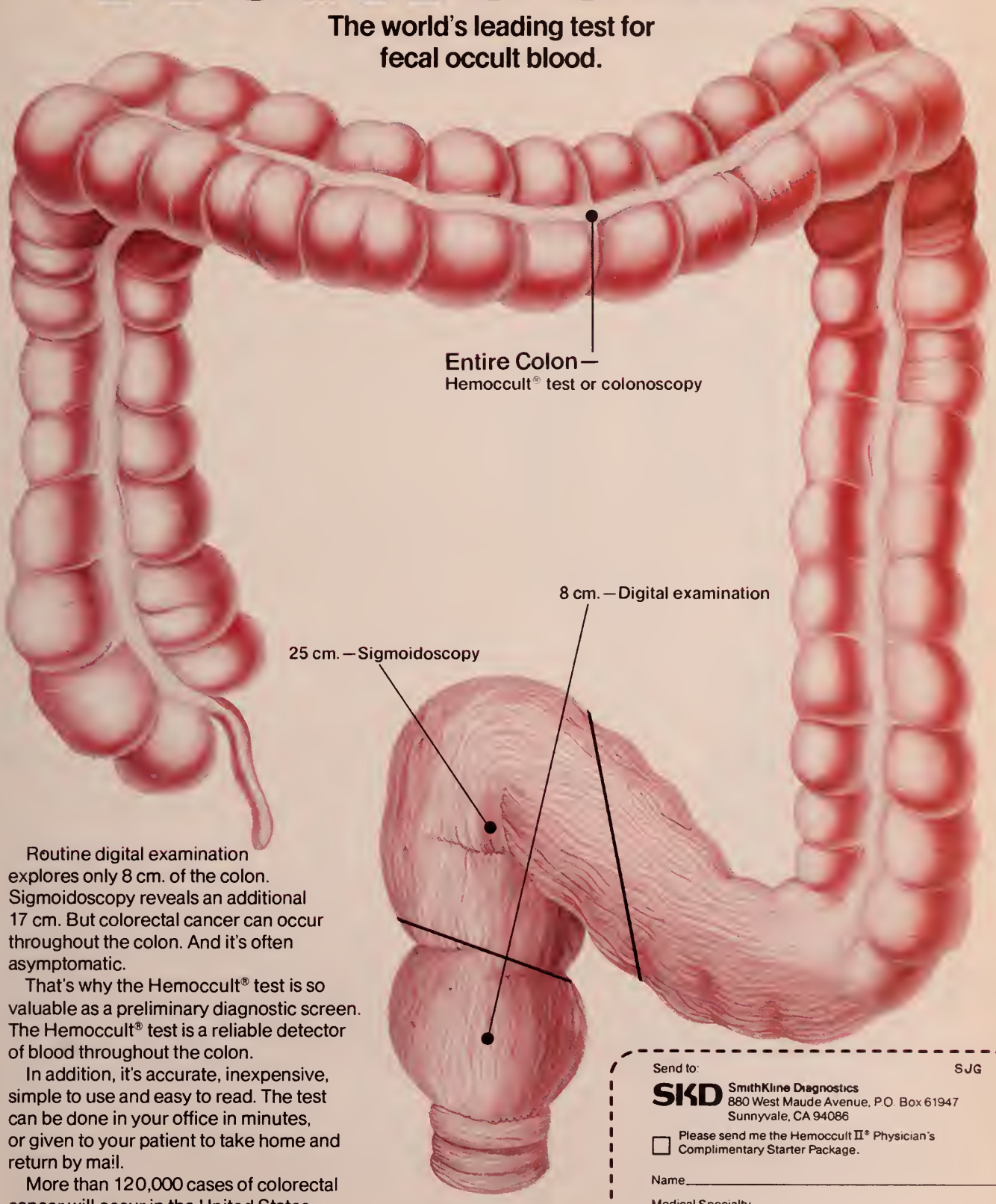
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For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

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DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.) Ⓒ III

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No 2 and No. 3 is one or two tablets every four hours as required The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 7-11, 1981, Chicago; James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 113th Annual Session, April 26-30, 1981, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 29-August 1, 1981, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Howard Memorial Hospital
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

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PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

FAMILY PRACTITIONER seeks practice location in Mississippi. Graduate of University of Washington School of Medicine, 1950. Presently practicing in Alaska. Contact Donald F. McKay, Box 631, Haines, AK 99827.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

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PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

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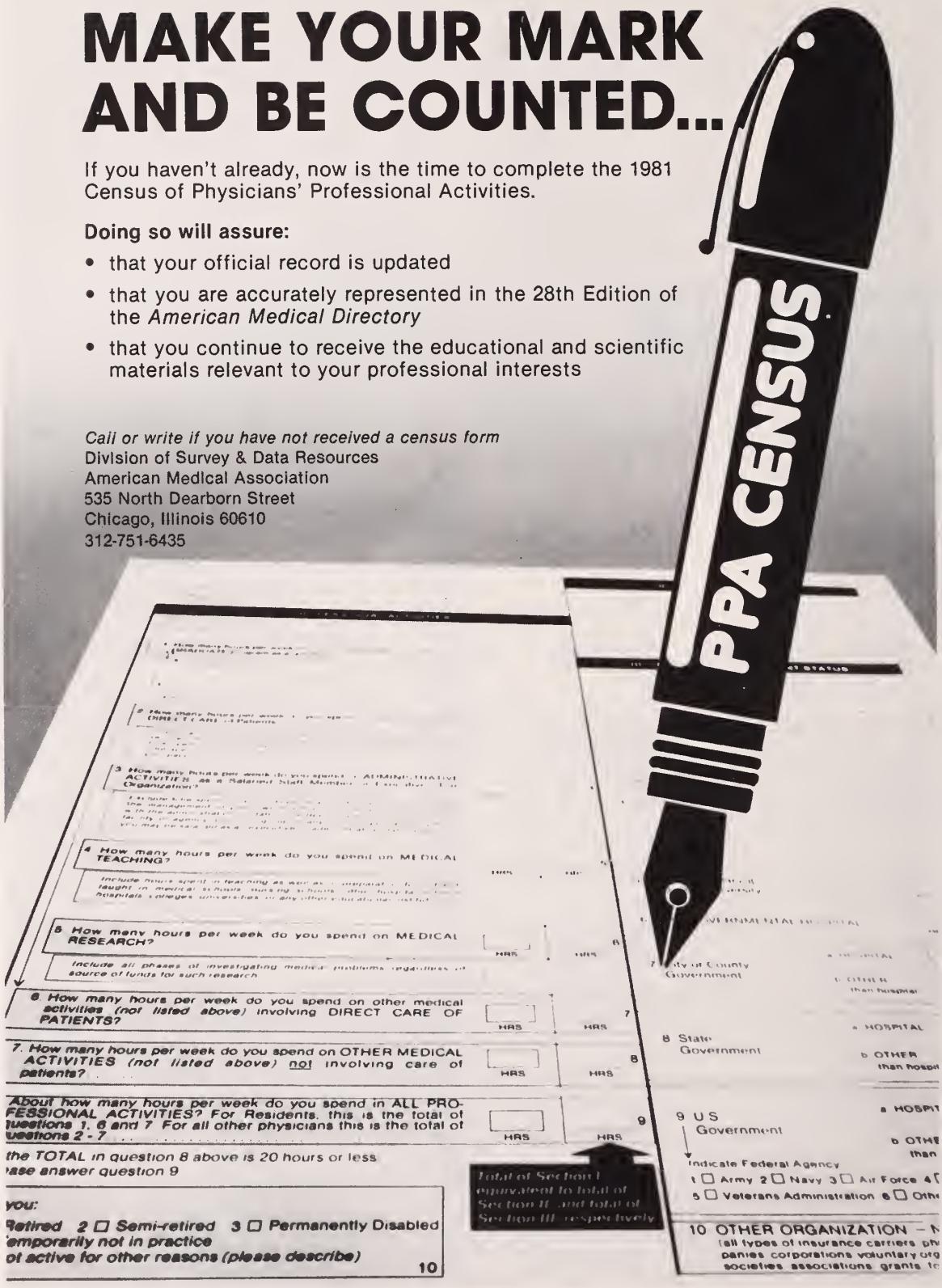
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- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introi colonization by fecal uropathogens. It has *no* signifi cant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

April 1981

BALCONY

JOURNAL of the MISSISSIPPI State Medical Association



113th Annual Session

April 26-30, Biloxi

Inside:
Complete Program

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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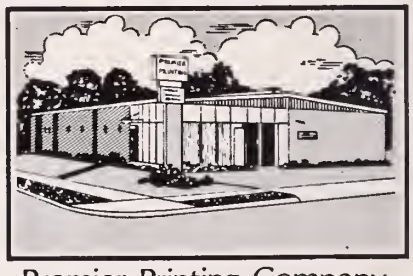
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April 1981, Volume XXII, Number 4

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After one week of penicillin V-K therapy



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Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

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Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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ACR-55

NEWSLETTER

April 1981

Dear Doctor:

This issue contains the complete programs for MSMA's 113th Annual Session and the MSMA Auxiliary's 58th Annual Session, which begin April 26 at the Biloxi Hilton. AMA President Dr. Robert Hunter and U.S. Senator Thad Cochran are among special guest speakers slated for the five-day session. Dr. Hunter will address the House of Delegates on Monday morning, April 27, and Sen. Cochran will speak at the Miss. Foundation for Medical Care meeting that afternoon.

> A number of special events have been planned, including a golf tournament, tennis tournament, fishing rodeo, and meetings of specialty societies and medical alumni groups. There will also be an art exhibit featuring works by MSMA members and spouses. Room reservations should be made directly with the Hilton.

For the first time since July 1980, the increase in physicians' fees exceeded the general monthly inflation rate. In January physicians' fees rose at a rate of 1.3%. The Consumer Price Index all-items component rose 0.8%, and the all-services component rose 1.1%. Hospital room charges increased 2.3%, dental services rose 1.1%, and prescription drugs increased 1.2%.

Five deaths have resulted from the ten confirmed cases of meningococcal meningitis reported in the state since Jan. 1. The sporadic outbreaks are not considered to be greatly increased over last year, according to State Board of Health epidemiologists. Louisiana officials report 42 cases so far this year in that state, with ten deaths.

The FDA has responded to the Reagan Administration's order to scrutinize regulations by halting implementation of the patient package insert (PPI) program, scheduled to begin in May. The AMA was among those objecting to the program, and in February had asked HHS Secretary Schweiker for a moratorium on the PPIs to permit a review of the program.

The Mississippi Museum of Art is seeking donations from physicians to finance the "Art of Healing" exhibition, which will be in Jackson from April 10 to June 7. To send your tax-deductible contribution or to receive information about the benefits of different sponsorships, write to the museum director at P.O. Box 1330, Jackson, MS 39205 or call (601) 354-3538.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness, emotional problems, or substance abuse, it is the only hospital of its kind in the state.

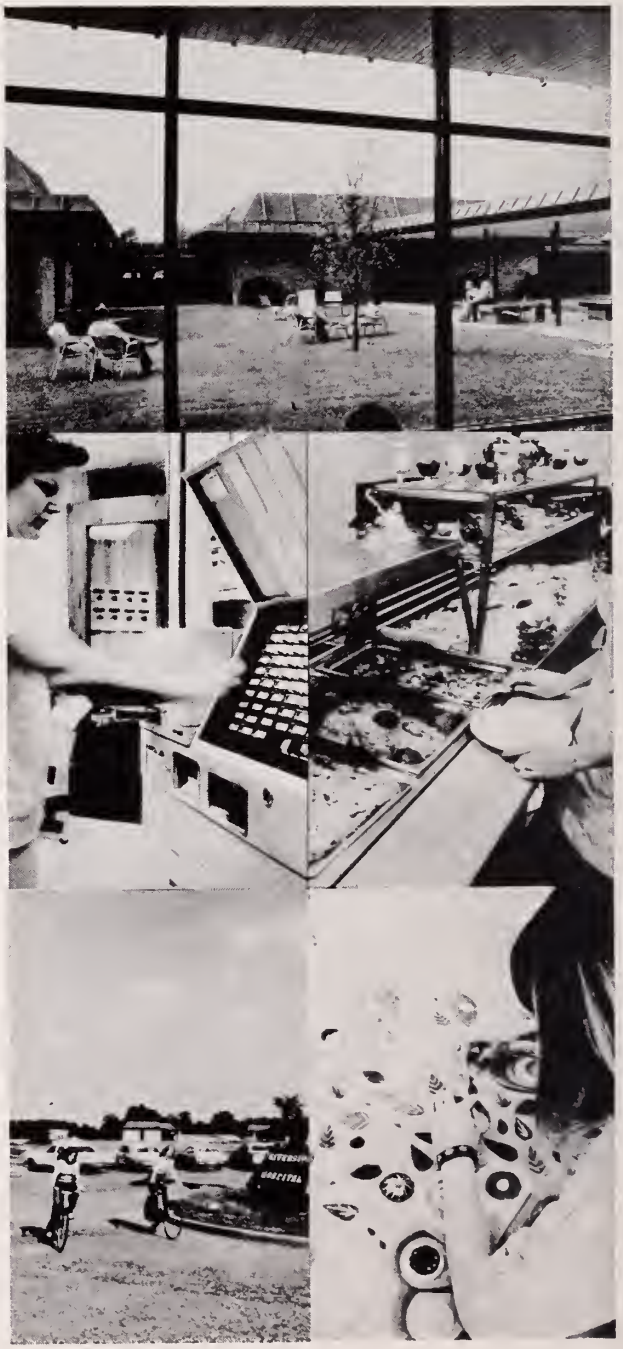
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine. Some of our better known products are Lopurin™ , Ru-Tuss® and Ru-Vert® . This advertisement highlights four other products particularly useful for the family.

F-E-P CREME® • SU-TON® • TWIN-K® • TWIN-K-CI™



For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin – Pramoxine HCl – Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (½ ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.



For Potassium Supplementation Improved Compliance...

TWIN-K®

Each 15 ml supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

The good tasting potassium supplement

- Designed for prophylactic and therapeutic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient dosage aid patient compliance.
  The organic salt of potassium can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine.[1]

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, WB. Saunders Co., Philadelphia, page 1959.

In Cases with Chloride Deficiency...

TWIN-K-Cl™

Each 15 ml supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride in a sorbitol and saccharin solution

The good tasting potassium supplement with chloride

- In hypokalemic hypochloremic alkalosis, chloride ions are required. Twin-K-Cl is specially formulated to be a good tasting chloride containing potassium supplement.
- Contains no potassium chloride. Twin-K-Cl is a carefully balanced combination of organic potassium salts plus ammonium chloride.
- In hypochloremic patients, potassium should be provided as the chloride salt, or chloride ion must be made available in some other form, such as ammonium chloride or sodium chloride.[1]

See prescribing information on last page of this advertisement.



F-E-P CREME

DESCRIPTION

F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective. Contact or atopic dermatitis; impetiginized eczema; nummular eczema, infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma, nuchal eczema and chronic eczematoid otitis externa, acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris corporis, pedis), moniliasis; intertrigo. Final classification of the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS

Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella)

WARNINGS

This product is not for ophthalmic use

In the presence of systemic infections, appropriate antibiotics should be used

USE IN PREGNANCY

Topical steroids have not been reported to have an adverse effect on pregnancy However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy

PRECAUTIONS

F-E-P Creme may be irritating to the skin in some patients If irritation occurs discontinue therapy Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period

Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests. The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine

Prolonged use of this drug may result in an overgrowth of non-susceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS

Skin rash or hypersensitivity may occur following topical application.

The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur

DOSAGE AND ADMINISTRATION

Apply a thin layer of the drug to affected parts 3-4 times daily

Note:

1 F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.

2 F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics

HOW SUPPLIED

F-E-P Creme	½ ounce (15 gm) tubes	NDC 0524-0026-51
F-E-P Creme Plain	½ ounce (15 gm) tubes	NDC 0524-0025-51

Federal law prohibits dispensing without a prescription

July 1980

SU-TON®

DESCRIPTION

Forty-five milliliters of SU-TON contain the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE

SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency

CONTRAINDICATIONS

Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS

The safety of this preparation during pregnancy and lactation has not been established Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child

PRECAUTIONS

Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS

Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE

Drug dependence has not been reported with SU-TON

OVERDOSAGE

Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance The symptoms may include the following vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia Treatment consists of appropriate supportive measures If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage

Intensive care must be provided to maintain adequate circulation and respiratory exchange

DOSAGE AND ADMINISTRATION

One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals This drug is not for use in children under 12 years of age

HOW SUPPLIED

8ottles of 473 ml (16 fl oz) NDC 0524-0015-16

Federal law prohibits dispensing without prescription

February 1980

TWIN-K®

DESCRIPTION

Each 15 milliliter (one tablespoonful) supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

INDICATIONS AND USAGE

For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication

CONTRAINDICATIONS

Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause This product should not be used in patients receiving aldosterone antagonists or triamterene

WARNINGS

TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation, it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS

Potassium is a major intracellular cation which plays a significant role in body physiology The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia

The most common cause of hypokalemia is excessive loss of potassium in the urine However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS

Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort

OVERDOSAGE

The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes Treatment measures include

1. Elimination of potassium containing drugs or foods
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters
3. Correction of acidosis
4. Use of exchange resins or peritoneal dialysis

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly

DOSAGE AND ADMINISTRATION

The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of potassium ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED

Bottles of 1 pint (16 fl oz) NDC 0524-0021-16

CAUTION

Federal law prohibits dispensing without prescription.

July 1980

TWIN-K-CI™

DESCRIPTION

Each 15 ml (one tablespoonful) supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride, in a sorbital and saccharin solution.

INDICATIONS

For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Potassium and chloride are usually the salts of choice in the treatment of hypokalemia since chloride and potassium deficiencies are likely to be associated with each other

CONTRAINDICATIONS

Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene

WARNINGS

TWIN-K-CI is a palatable form of oral potassium replacement Excessive, undiluted doses of TWIN-K-CI may cause a saline laxative effect

To minimize gastrointestinal irritation, it is recommended that TWIN-K-CI be taken with meals or diluted with water or fruit juice A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS

Potassium is a major intracellular cation which plays a significant role in body physiology The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions TWIN-K-CI is recommended for use in these patients

ADVERSE REACTIONS

Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block Hyperkalemia may exhibit the following electrocardiograpic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K-CI taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort

OVERDOSAGE

The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes. Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters
3. Correction of acidosis
4. Use of exchange resins or peritoneal dialysis

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly

DOSAGE AND ADMINISTRATION

The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day This will supply 30 to 60 mEq of potassium ions and 8 to 16 mEq of chloride ions The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K-CI are to be avoided

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects

HOW SUPPLIED Bottles of 1 pint (16 fl oz)

NDC 0524-0022-16

MANUFACTURED & DISTRIBUTED BY

Boots Pharmaceuticals, Inc.

Shreveport, Louisiana 71106

Pioneers in Medicine For the Family

More physicians *are coming to MMFES because MMFES does more for physicians.*

The active and involved physician has to rely on comprehensive insurance programs tailored to fit the day-to-day special needs of his profession.

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COM KEY SYSTEMS

TALK, PAGE, PLAY MUSIC, CALL CONFERENCES, GUARD YOUR PRIVACY, AND WORK OVERTIME.
ALL THIS, PLUS BELL SERVICE THAT DOESN'T QUIT.



Com Key* systems are a whole new family of phones that can adapt to your business needs. Designed to give you better, faster telecommunications With your employees, customers, and suppliers

If your business requires several phone lines, we have a Com Key system that can handle up to 21 incoming lines and route calls to as many as 52 stations But, if your needs aren't that large, investigate others in our Com Key family—a smaller system may ideally answer your needs

Standard features on all Com Key systems include.

• Two distinctive tones that let you distinguish internal from external calls If you're already on the phone, a muted verbal message or tone lets you know another call is standing by

• Multi-line conferencing that can connect your business line with two or more outside lines

• Line buttons that pop up automatically when you hang up to minimize the chance of someone inadvertently picking up during your conversation

• Your choice of console faceplates, in colors or woodgrain, to complement office decor

Optional features include

• A ringing feature that keeps your phones working even if outside power fails.

• Paging systems that can broadcast messages to an entire office area or to specific departments Or carry background music (That same music can be piped into the system's "hold" function, for waiting callers.)

• A night transfer option (standard on the model 416) to connect after-hours incoming calls to any phone in your system.

• A privacy feature that keeps your conversations confidential when needed

• Pre-set conferencing that will ring preselected combinations of phones simultaneously (a feature that could make lots of office memos obsolete)

Two more important considerations in any business phone decision: service and maintenance At Bell, we take total responsibility

So, before you choose a new office telephone system, call in a South Central Bell Account Executive at no extra cost And get the total story on Com Key systems.

South Central Bell

*Trademark of AT&T

DATELINE

Art Exhibit at Annual Session

Jackson, MS - Physicians and their spouses are invited to participate in an art exhibit during MSMA's 113th Annual Session in Biloxi later this month. The work can be in any medium, recent or not, and does not have to be for sale. First, second and third place awards will be presented by Judi Betts of Baton Rouge, noted artist and instructor. For information, contact Mrs. J. O. Manning, 2025 E. Northside Drive, Jackson, MS 39211.

EMS Symposium Is Next Month

Jackson, MS - A dozen different continuing education workshops are offered for physicians, nurses, EMTs and other health care professionals attending the 1981 EMS Statewide Symposium. Among the topics are: care of the patient with facial injuries, medical management of overdosed patients, neonatal care and transport, environmental injuries, trauma centers, and cardiac drugs. MSMA is affiliate sponsor of the symposium, scheduled for May 27-29 in Biloxi.

Shortage of Nurses Affects State

Jackson, MS - The nationwide shortage of nurses which began in the 1970s continues to affect Mississippi, despite vigorous recruiting efforts on the part of many state hospitals. Some 247 nursing staff vacancies exist at three Jackson hospitals, and a fourth hospital reports a 10% shortage. The continuing decline in enrollments reported by officials at state nursing schools is said to be typical of a nationwide trend.

Physician Population Continues Increase

Chicago, IL - There were 17,078 more physicians in the U.S. and possessions in 1979 than in the previous year, according to the AMA publication "Physician Distribution and Medical Licensure in the U.S." The 1979 figures show that there were 356,783 physicians in direct patient care. Seventy percent of those were in office-based practice. There were 96,605 foreign medical graduate physicians and 50,604 women physicians in the total.

Sunbelt Reports Melanoma Increase

Chicago, IL - The incidence of malignant melanoma in southern Arizona increased 340% in a ten-year period, says a report in Archives of Dermatology. In 1969, 20 malignant melanomas were reported. That figure climbed to 120 in 1978. The highest incidence was in the age brackets of 50 to 59 and 60 to 69. The area has more sunlight, more clear days and less daytime cloudiness than any other area in North America, increasing exposure to ultraviolet light.

When painful spasm is the presenting symptom...



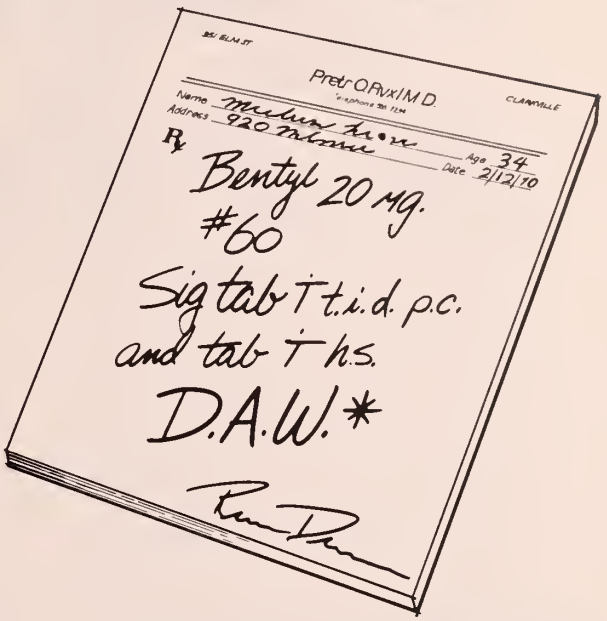
...in the functional bowel/irritable bowel syndrome†

be sure to specify

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



*D.A.W.-Dispense as written

because:

Bentyl passes these tests for product integrity.

- The Bentyl molecule is a product of original Merrell research.
- At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- Bentyl bioavailability of tablets, capsules, syrup and injectable.
- The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- Pharmacologic effect in the distal colon compared to placebo†† shows how Bentyl affects abnormal motor activity in the irritable colon patient.†

†This drug has been classified "probably" effective for this indication.

Merrell

†† In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)
Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIDNS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective:
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL OISOROERS ARE OFTEN RELIEVEO BY VARYING COMBINATIONS OF SEOATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CDNTRAINDICATIDNS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.
Use with caution in patients with:
Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.
Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.
Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
Oo not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

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Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily
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NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

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Ob-Gyn Alumni Meet at UMC



Members of the University of Mississippi Medical Center ob-gyn alumni group met at the Medical Center Feb. 13 and 14. Speakers included, from left, Dr. Ramon McGehee (a UMC School of Medicine 1975 graduate), fellow in gynecology-oncology at M.D. Anderson Hospital and Tumor Institute in Houston, TX; Dr. David H. Nichols, professor of ob-gyn and chairman of the department at Brown University School of Medicine in Providence, RI; and Dr. Raymond A. Lee, professor of obstetrics and gynecology at Mayo Medical School and consultant in gynecological surgery.

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Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose of in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H. influenzae*.

Note Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

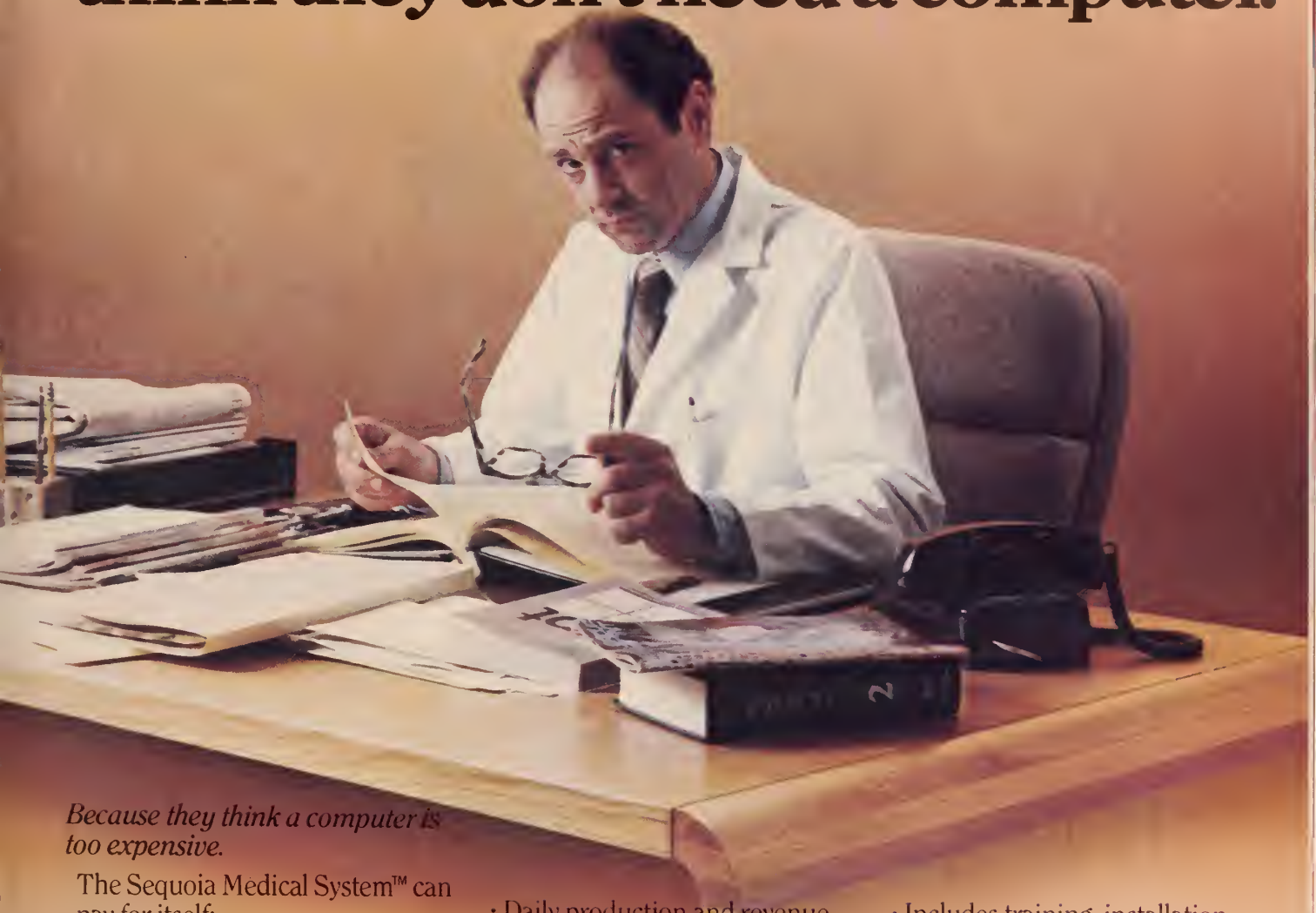
1 Antimicrob Agents Chemother , *8* 91, 1975
2 Antimicrob Agents Chemother , *11* 470, 1977
3 Antimicrob Agents Chemother , *13* 584, 1978
4 Antimicrob Agents Chemother , *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880. Washington, D C. American Society for Microbiology, 1978
6 Antimicrob Agents Chemother , *13* 861 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Radiologic Seminar CCXIII: Metastatic Hepatoma Simulating a Primary Colonic Adenocarcinoma on Barium Enema

SANDRA A. RHODEN, M.D. and W. THOMAS RUEFF, M.D.,* Jackson, Mississippi
SIDNEY JOHNSON, M.D.,† Goodman, Mississippi

THERE ARE A NUMBER of radiographic "classical" findings or "virtually pathognomonic" findings the student of radiology learns. He also goes on to learn that even with identification of such findings on an imaging study (be it from a radiographic, ultrasonic or other imaging modality), the shrewd radiologist still has to remember the zebras along with the horses when he hears hoofbeats in the night. He still has to remember he does not have a tissue specimen under a microscope when he views a radiographic image. In other words, many times he has to straddle the fence with his diagnosis. This is oftentimes much to the dismay of the referring physician. They sometimes dislike those so-called gamuts of differential possibilities when the single answer seems to be staring everybody in the face. Everybody knows the radiologists' favorite phrase: "This is consistent with, but not diagnostic of . . . " Is there any wonder that rumor has it that the radiologists' national flower is "the hedge"?

The following interesting case report is presented as an unusual radiographic presentation of hepatoma which presented as a "classical" radiographic demonstration of a primary lesion of the colon with metastases to the liver.

Sponsored by the Mississippi Radiological Society.
* From the Mississippi Baptist Medical Center, Jackson, MS.
† From Holmes County Hospital, Lexington, MS.

Case Report

A retired 69-year-old man with abdominal pain, nausea, occasional vomiting, and ten-pound weight loss presented for evaluation. Physical examination revealed a chronically ill, emaciated male with a markedly enlarged, tender and nodular liver. Laboratory results revealed CEA 2.6, normal alpha fetoprotein of 12, hemoglobin of 7, hematocrit of 20, WBC 9,200, NCV of 77, SGOT 100, LDH 250, alkaline phospatase 400, and total bilirubin of 2. Chest x-ray was normal except for some suspected mild emphysematous changes.

A real time ultrasound examination of the upper abdomen was done by the radiologist and a moderate amount of ascites was noted (see Figure 1). There was also noted an enlarged liver with multiple focal solid nodular areas of varying acoustical characteristics. The margin of the inferior aspect of the right lobe of the liver was not distinguishable. There was noted an approximately five-centimeters in diameter, somewhat irregularly spherical, highly echogenic solid mass at the level of the inferior right lobe of the liver; there were some anechoic barely resolvable spaces centrally. It could not be determined if this lesion represented a primary lesion of the liver or a metastatic lesion, or if there was invasion of contiguous structures (colon?) or if this represented an extra-hepatic lesion (colon?) with extension to adjacent liver.

The routine barium enema (see Figure 2) revealed a stenosed, approximately four-centimeter segment of colon in the hepatic flexure with overhanging edges and a "classical apple-core" or annular type of configuration. There was noted caudal displacement of the hepatic flexure and transverse colon by what was felt to represent previously palpated and ultrasonically visualized grossly enlarged liver (see Figure 3). An isotope liver scan revealed enlargement of the liver with marked involvement of the left lobe which was interpreted as compatible with extensive metastatic involvement (secondary to a primary in the colon).

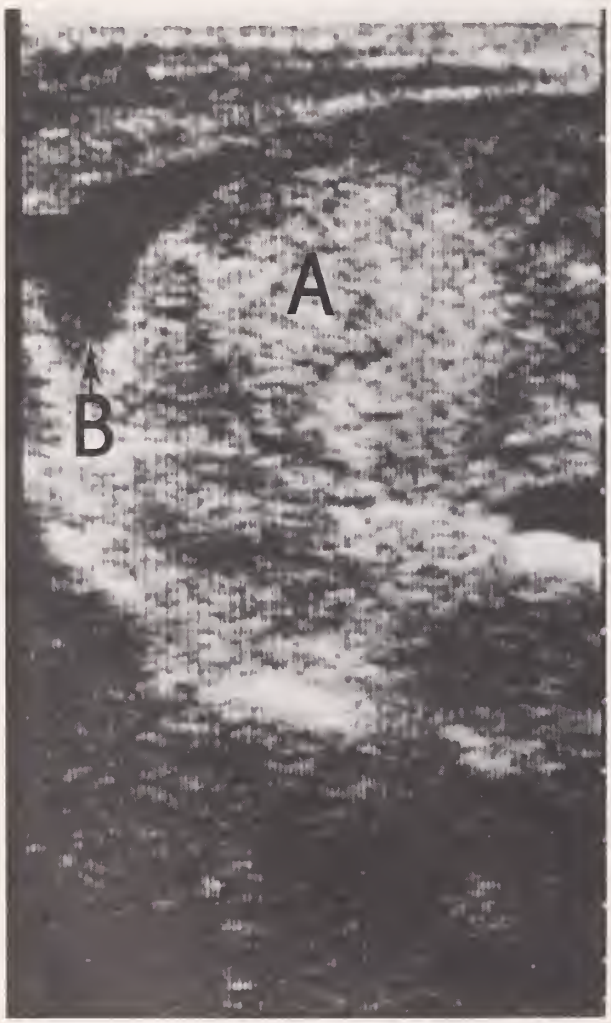


Figure 1. Real time ultrasound transverse section through most inferior part of right hepatic lobe. Black crescent shaped space above "B" is ascites lateral to right lobe of liver. "A" is a 4-5 cm solid mass involving the inferior right lobe.

The patient underwent exploratory surgery to relieve symptoms of partial obstruction secondary to the colonic lesion. There were approximately 1200 cc of ascitic fluid in the abdomen. The liver was found to be markedly enlarged and at least half of the liver parenchyma was replaced by what appeared to be metastatic disease. Wedge biopsy was done and the frozen section returned a diagnosis of hepatocellular carcinoma, moderately differentiated, arising in multilobular cirrhosis. The segment of stenotic colon was adherent to the under surface of the liver secondary to what appeared to be serosal metastasis. Due to brisk oozing during an attempt to separate liver from colon, it was elected to do an ileotransverse colostomy. Due to widespread liver involvement, it was elected not to inject chemotherapeutic agents directly into the liver intravenously.

Discussion

The purpose of the discussion will be directed at a review of two areas: (1) Comparison of radiographic findings in primary colonic neoplasms and in metastatic colonic neoplasm and (2) a review of the clinical presentation of hepatoma and an approach to its diagnosis.

Tumors of the colon. A colonic metastasis may simulate a sharply demarcated flat or annular neoplasm, or it may appear as a longer, concentric, stenotic lesion with tapered edges. Metastatic lesions may also cause shallow, extrinsic pressure defects against the bowel wall, or the overlapping edge of uninvolved bowel may mimic an intramural, extramucosal tumor. Mucosa is rarely effaced but may show transverse ridging. Nodular filling defect, mucosal ulceration, or obstruction may occur in the late stages.[1]

Metastatic lesions to large bowel are often multiple, which helps in differentiating this from primary carcinoma. However, even this might often be confused with segmental inflammatory bowel disease. Eccentric strictures, mucosal nodularity, marginal ulceration, speculation and rigidity may all be present, and these different forms and sites may well mimic inflammatory bowel disease. Metastic encasement of colon may occur, especially with contiguous spread of carcinoma from the stomach or ovary.[1]

On the other hand the terms annular carcinoma or napkin ring carcinoma or applecore carcinoma are usually reserved for some primary carcinomas of the colon. The predominant characteristics of an annular carcinoma are extensive infiltration and rigidity of the bowel wall, rather than formation of an intraluminal polypoid filling defect, another form which



Figure 2. Segment of narrowed colon between the areas was several centimeters in length and had a typical "apple-core" appearance.



Figure 3. White line spans the distance between the right hemidiaphragm and the hepatic flexure. This space is abnormally increased. Dark arrows point to the stenotic lesion in the hepatic flexure region.

primary carcinoma of the colon often takes. The bowel lumen may be narrowed by an annular carcinoma and the abrupt change from normal bowel to tumor results in a so-called "tumor shelf" at the proximal and distal ends of the mass. The annular primary colonic tumor may evolve from a polypoid tumor but most commonly from a flat or saddle type of lesion. In contrast with diverticulitis the annular carcinoma extends over a relatively short segment of bowel and the mucosa through the narrowed central core is ulcerated.[2]

Location of an annular primary lesion of the colon can be anywhere, although left colonic lesions tend to be either annular or flat and ulcerated and tend to cause symptoms earlier due to bleeding and obstruction. Those colon carcinomas in the right colon tend to grow larger in the more distensible right colon, where bowel contents are semiliquid; obstructive symptoms are less and blood loss is usually occult.[1] Either annular or polypoid tumors in the colon may cause total obstruction or more commonly, there will be apparent retrograde obstruction to the flow of barium.[1] But one has to remember inflammatory lesions also when an obstructing lesion of the colon is found.[3]

Hepatoma. The cause of primary hepatocellular carcinoma is unknown, but cirrhosis is found in two-thirds of patients with hepatoma and it is either Laennec's cirrhosis or post necrotic cirrhosis. It is found in 20% of patients with post necrotic cirrhosis. Patients may be deteriorating for no particular reason, as in this case. Cachexia, weakness, weight loss and epigastric or right upper quadrant pain are common. They are rarely jaundiced and gastrointestinal bleeding is common. Alpha-fetoprotein is frequently positive but absent in other malignancies of the liver. Thirty percent are hypoglycemic; alkaline phosphatase and transaminase are almost always abnormal. In metastatic disease to the liver these values are usually elevated without elevation of other liver function studies, and indeed, all functions may be normal. An increased indirect bilirubin is extremely common with metastatic disease to the liver.[4]

Diagnostic imaging of the liver with hepatoma will be quite non-specific if ultrasound is done, since the hepatocellular carcinoma has a spectrum of morphologic appearances, from focal mass to diffuse infiltrative spread, and gray scale findings reflect this variability.[5] A reasonable investigative work-up

where hepatoma is suspected should include alpha-fetoprotein assay, technetium 99m sulphur colloid scans (hepatoma will be "cold"), and gallium citrate tumor imaging (90% of cases avidly seek this isotope). Angiography might be done then for confirmation and possible guide for resection.[6] Although not necessary in the work-up, it is of interest to note that CT has a 79% accuracy of identifying these tumors; this is due to the large size of some of the tumors and the isodense appearance of some of the tumors, even following contrast.[7]

Summary

Although this patient's prognosis and management would not have been significantly altered by the difference in preoperative and postoperative diagnosis, the case serves as a reminder of the fact that radiography is not always specific. The case gives one the opportunity to review radiographic features of primary and metastic neoplasm of the colon and to recognize they may not be as "pathognomonic" as they appear to be on the surface. The clinical presentation and laboratory findings of hepatoma are reviewed. Finally, an investigative scheme is offered for use in those patients in whom a primary hepatocellular neoplasm is suspected. ★★★

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References

1. Dreyfuss, Jack R. and Janower, Murray L.: Radiology of the Colon. Williams and Wilkins Co., 1980, p. 423-475.
2. Robbins, Lawrence L.: Golden's Diagnostic Radiology: Section 5, Digestive Tract, 62nd Ed. Williams and Wilkins Co., 1969, 427-440.
3. Morris, S. J. et al.: Acute Ulcerative Colitis Mimicking an Obstructing Carcinoma of the Colon. Am. J. Gastroent. 70 (2):194-196, August, 1978.
4. Spiro, Howard M.: Clinical Gastroenterology. The Macmillan Co., 1970, p. 962-964.
5. Scheible, W., Gosink, B. B. and Leopold, G. T.: Gray-Scale Echographic Patterns of Hepatic Metastatic Disease. Am. J. Radiol. 129:983-987, 1977.
6. Broderick, T. W., et al.: Echographic and Radionuclide Detection of Hepatoma. Radiol. 135:149-151, April, 1980.
7. Itai, Y., Nishikawa, J. and Tasaka A.: Computed Tomography in the Evaluation of Hepatocellular Carcinoma. Radiol. 131:165-170, April, 1979.

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The President Speaking

Let's Get Back to Grass Roots

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

To us country boys, the term "grass roots" may have a different connotation than to most people, especially if we happen to be row farmers. We are hearing this term thrown about more and more these days. People are saying, "let's get back to the grass roots . . . ground floor . . . or to the basics." What we are really saying is, "let's make everything simple . . . reduce the paperwork . . . handle it on the local level . . . keep it out of the hands of the big city slickers, especially the Washington bureaucrats." Sometimes it seems that this is only talk — that we really don't mean what we are saying. I think that we should.

President Reagan still tells us that he wants to decentralize the federal government, as his campaign platform stated. He wants to send each state a sack of money and let it be their responsibility how and on whom it is to be spent. This sounds good, and it is what a majority of the American people have stated that they want. Almost immediately we are now hearing the state and local officials crying out that it won't work. They complain, "We do not want the responsibility . . . the Feds won't send us enough . . . we won't get our fair share and besides, who said that this was the states' responsibility . . . these are federal problems . . . let the federal government take care of it."

It seems that when it gets down to the basics, we are admitting that we do not want to bite the bullet. We are admitting that we trust the federal government more than we do our local and state government. We are afraid we won't get our fair shake, that too much will go to certain local interest groups, while others will suffer. We are really afraid of the grass roots. We are not so sure that only a select few will not get all the roots.

We hear about a candidate or a project being successful because of support at the grass roots level. This sounds good, but I doubt seriously if this happens to a large degree. It appears that sooner or later the "big guns" move in. It appears to me that the weakest levels of government are the local or state components, but this should not be the case. However, if local leaders are not good ones, we are probably better off with someone from above dictating to us. It is, however, everyone's responsibility to see that we do have good local and state officials.

As I have traveled over the state and have also had the pleasure

(Continued on page 82)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 4

APRIL 1981

Congratulations, MSMA and MMFES!

The members of the executive staff of the Mississippi State Medical Association and the Mississippi Medical Fraternal and Educational Society are to be congratulated on their recent malpractice seminar held in Jackson. Those in attendance were held at rapt attention by an outstanding group of speakers composed of doctors, lawyers, and judges. Both plaintiff and defense lawyers were present to present opposing views of the doctor on trial. One physician who was sued presented the entire trial replete with videotape recordings of depositions. He won his suit.

The keystone to not being sued is prevention. Good rapport between physician and patient is of utmost importance in avoiding a lawsuit. Should a bad result occur, adequate legible office and hospital records are a must. For legal purposes anything not in writing is hearsay.

In this time of increasing suits against doctors, one must be constantly alert for the possibility of being sued. Seminars such as the one held recently do much to educate the physician, not only in the avoidance of suits but also in how to aid his lawyer in his defense.

GEORGE H. MARTIN, M.D.
Associate Editor

Medico-Legal Brief

Jury Exonerates Medical Groups In Chiropractic Antitrust Case

A federal court jury in Illinois has entered a unanimous verdict in favor of several medical organizations and individuals accused by chiropractors of conspiring to restrain their trade.

The plaintiffs, five individual chiropractors, filed the case in October 1976, against the American Medical Association, the American Osteopathic Association, the Americal Hospital Association, the Joint Commission on Accreditation of Hospitals, five medical specialty societies, state and local medical societies and several individual defendants.

The five chiropractors claimed that these defendants had conspired to monopolize health care services and to unreasonably restrain duly licensed chiropractors from competing with physicians in providing health care services. They also charged the defendants with conspiring to isolate and eliminate chiropractic as an "unscientific cult" and the practice of chiropractic as a hazard to the health of the public. They claimed loss of income due to denial of access to hospitals and referrals from physicians.

In its defense, the defendants assessed that they had acted in the public interest in protecting the public from unsafe or ineffective health care.

The jury, after an eight-week trial, found that none of the defendants had conspired to restrain the trade of chiropractors within the meaning of the Sherman Antitrust Act. The jury also found that the defendants had not conspired to monopolize nor attempted to monopolize any of the "markets" for health services which the plaintiffs alleged to exist.

The jury voted unanimously for acquittal. — *Wilk v. American Medical Association*. Docket No. CA-76-3777 (D.C., Ill., Jan. 30, 1981)

113th Annual Session

Biloxi Hilton, April 26-30

- 14 Scientific Sections
- Seminar (Diagnostic Approaches to Some Common GI Problems)
- Specialty Society Meetings
- House of Delegates
- Tennis, Golf, Deep Sea Fishing
- Art Exhibit
- Annual Fellowship Party

and privilege of attending meetings and seminars involving organized medicine at the national level, I have come to the conclusion that the weakest link in organized medicine is the local component society. The reason for this is we don't have people input and participation. One would hope that we are spending all our time and efforts locally taking care of the sick, but I am afraid that this is not the case. What is happening is we are allowing our hired hands to make most of the decisions about the future of American medicine. In general, I believe they have done a credible job, but this is not the way it should be. In my opinion, most physicians appear not to give a tinker's damn about the happenings of medicine until some law is enacted or guideline passed which goes against their grain. Then immediately they turn to the three or four who are trying to keep the home fire burning and want to know why they are not representing them better.

If we as physicians could come to understand that with only a minimum of time and participation the local medical component could be strong and influential, then organized medicine throughout the country would have much grass roots flavor. But without local input, how can we expect laws to be enacted or guidelines published which have local flavor? If we really did our homework and tried to solve our problems before they happened, there would be no group or organization that could dictate to organized medicine. After all, we deliver the best health service in the world by the most respected group of professionals.

Make those reservations today, if you have not already, for the MSMA Annual Session on the beautiful Gulf Coast. Come tell your colleagues and House of Delegates those thoughts and ideas you have, lest you forget them before anyone else knows.

RECOLLECTIONS

Twenty years ago the April JOURNAL MSMA published the program for the 93rd Annual Session of the association, to be held at the Buena Vista Hotel in Biloxi. Association president Dr. G. Swink Hicks of Natchez was scheduled to address the House of Delegates, along with the president-elect of the AMA, Dr. Leonard W. Larson of Bismarck, ND. The inauguration of Dr. Lawrence W. Long of Jackson as MSMA president was included in the agenda for the closing session of the House of Delegates.

General chairman of the annual session, Dr. C. D. Taylor, Jr., of Pass Christian, and Council on Scientific Assembly chairman Dr. William E. Lotterhos of Jackson, had assembled the program. Among speakers scheduled to make presentations before the seven scientific sections were: Dr. Raymond F. Grenfell of Jackson, "A Double Blind Study of the Treatment of Hypertension"; Dr. Thomas E. Weiss of New Orleans, "Rheumatoid Arthritis — Typical and Atypical"; Dr. C. G. Sutherland of Jackson, "Ruptured Uterus"; Dr. Blair E. Batson of Jackson, "Immunizations, Past, Present and Future"; Dr. J. T. Davis of Corinth, "Closure of Wounds of the Hand"; and Dr. Richard T. Farrior of Tampa, FL, "Management of Facial Injuries."

News stories in that issue reported that 40 percent of the nation's population was not yet inoculated against polio, prompting the American Medical Association to take action to stimulate a nationwide immunization campaign. Another article observed that medical charlatans were receiving some $610 million each year, largely from the sale of quack health machines, a business that was flourishing because of the public's gullibility and because of legal loopholes.

In that issue, it was reported that the cost of living has risen 1.5% in 1960, and that taxes were taking one dollar out of every four dollars earned by the majority of American families. The Tax Foundation revealed that in 1960 more than four out of five U.S. families had annual incomes between $2,000 and $15,000 and were paying about 70% of the nation's total tax bill.

Scientific articles published in that same issue of the journal included "Acute Pancreatitis: Diagnosis and Treatment," by Dr. Frank A. Wood of Jackson and "Case Report V of Maternal Mortality Study: Amniotic Fluid Embolism," by Dr. Michael Newton of Jackson.

113th Annual Session

Mississippi State Medical Association
April 26-30, 1981
Biloxi

The sunny Gulf Coast beckons Mississippi physicians and their families as the 113th Annual Session of the association gets underway April 26 at the Biloxi Hilton Hotel. Fourteen scientific sections, sixteen specialty societies and related groups, four medical alumni social occasions, scientific exhibits, the House of Delegates, and a host of fellowship events are slated for the five-day meet.

Principal speakers at the opening session of the House of Delegates will be Dr. Robert B. Hunter of Sedro Woolley, WA, president of the American Medical Association and Dr. Paul H. Moore of Pascagoula, MSMA president.

Delegates will receive their complete House of Delegates folders prior to April 26, according to House Speaker Carl G. Evers of Jackson and Vice Speaker Walter H. Rose of Indianola. In addition to hearing guest speakers and taking action on reports and resolutions, the agenda for House of Delegates meetings on Monday and Thursday call for the presentation of awards, election of officers, and the installation of Dr. R. Faser Triplett of Jackson as 1981-82 president.

Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly, said that the Assembly will open on Sunday morning, April 26, and continue through Wednesday afternoon, April 29. The Scientific Assembly has been approved for 16 hours Category I credit toward the AMA Physician's Recognition Award and also carries prescribed hour credits recognized by the American Academy of Family Physicians.

Among the many medical-related groups which have scheduled meetings in conjunction with the annual session are the Mississippi Foundation for Medical Care (Monday afternoon at 1:00) and the Mississippi Medical Fraternal and Educational Society (Sunday afternoon at 3:30). Senator Thad Cochran will address the Foundation's annual membership meeting, and Mrs. Betty Britton, patient representative at Mississippi Baptist Medical Center, will speak at the MMFES meeting.

The MSMA Auxiliary will conduct its 58th Annual Session during the week. Among special activities planned are a luncheon and fashion show on Tuesday, and a beauty and health clinic conducted by representatives of the Greenhouse, luxurious resort in Arlington, TX, on Wednesday.

The MSMA's annual fellowship party, featuring cocktails and hors d'oeuvres, is scheduled for Wednesday evening. Medical alumni from Ole Miss and the University of Tennessee will have social functions on Monday evening, and medical alumni from Tulane and LSU will host receptions on Tuesday evening.

Tennis and golf tournaments, a fishing rodeo, and an art exhibit featuring works of MSMA and Auxiliary members are just a few of the many other activities scheduled during the five-day convention.

Room reservations at the Biloxi Hilton should be made directly with the hotel.

OFFICIAL CALL

To all members of the Mississippi State Medical Association:

The 113th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Sunday, April 26, 1981, pursuant to Article V of the Constitution. The House of Delegates will be convened at the Biloxi Hilton at 9:00 a.m. on April 27.

The Scientific Assembly, consisting of the 14 Scientific Sections, will meet during April 26-29, 1981.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

PAUL H. MOORE
President

J. Elmer Nix
Secretary-Treasurer

PROGRAM

STATE OFFICERS 1980-1981



DR. MOORE



DR. TRIPLETT

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LIVING PAST PRESIDENTS

S. Lamar Bailey, Kosciusko	1955-56
Howard A. Nelson, Greenwood	1957-58
Guy T. Vise, Meridian	1958-59
Stanley A. Hill, Corinth	1959-60
G. Swink Hicks, Natchez	1960-61
Lawrence W. Long, Jackson	1961-62
C. P. Crenshaw, Collins	1962-63
Omar Simmons, Newton	1964-65
Everett Crawford, Tylertown	1965-66
James T. Thompson, Moss Point	1966-67
Temple Ainsworth, Jackson	1967-68
Joseph B. Rogers, Biloxi	1968-69
James L. Royals, Jackson	1969-70
Paul B. Brumby, Lexington	1970-71
Charles R. Jenkins, Laurel	1972-73
Arthur A. Derrick, Jr., Durant	1973-74
J. T. Davis, Corinth	1974-75
Lyne S. Gamble, Greenville	1976-77
James O. Gilmore, Oxford	1977-78
Carl G. Evers, Jackson	1978-79
Gerald P. Gable, Hattiesburg	1979-80

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located on First Level near the Grand Ballroom. No person may be admitted to any activity of the annual session without first registering. **There will be a registration fee of $75.00 for nonmember physicians except interns and residents.** Hours of registration will be: 8:00 a.m.-3:00 p.m., Sunday; 8:00 a.m.-4:30 p.m., Monday, Tuesday and Wednesday; and 8:00-9:00 a.m., Thursday.

EXECUTIVE BUSINESS



Dr. Evers
Speaker



Dr. Rose
Vice-Speaker

HOUSE OF DELEGATES
April 27, 1981
9:00 a.m.
Crystal and Topaz Rooms



Dr. Hunter

The opening meeting of the House will be called to order by the President, and the Speaker will announce the order of business. All MSMA members and Auxiliary members are invited to the open meeting, which will feature addresses by Dr. Paul H. Moore, president of MSMA, and Dr. Robert B. Hunter, president of the American Medical Association. The adjourned meeting of the House will convene at 9:00 a.m. on April 30.

REFERENCE COMMITTEES

Reports of Officers, Trustees and Councils, April 27, 2:15 p.m., Topaz Room
Constitution and Bylaws, April 27, 3:30 p.m., Pacific Room
Nominating Committee, April 29, 11:00 a.m., Dunes Room

ACTIVITIES CALENDAR

SUNDAY, APRIL 26

7:30 a.m.	Miss. EENT Association Breakfast	Stardust
	Miss. Dermatology Soeiety Breakfast	Pacific
8:00	MSMA Scientific Session — Section on Orthopedic Surgery	Emerald
	Miss. Society of Anesthesiology Breakfast	Topaz
9:00	MSMA Scientific Session — Section on Anesthesiology	Topaz
	MSMA Scientific Session — Section on Pathology	Crystal
	MSMA Scientific Session — Section on Psychiatry	Atlantic
	MSMA Scientific Session — Section on EENT (ENT's)	Stardust
	MSMA Scientific Session — Section on EENT (Ophthalmology)	Sands
	MSMA Scientific Session — Section on Radiology	Dunes
	MSMA Scientific Session — Section on Dermatology	Pacific
12:00 noon	Miss. Association of Pathologists Luncheon	Crystal
	Academy of Facial Plastic and Reconstructive Surgery Luncheon	Dunes
	Miss. Psychiatric Association Luncheon	Atlantic
12:30	Miss. Orthopedic Society Luncheon	Emerald
2:30	MMPAC Board Meeting	Pacific
3:30	Miss. Medical Fraternal and Educational Society, Inc. Annual Membership Meeting	Emerald
5:30-7:00	MSMA President's Reception	Crystal/Topaz

MONDAY, APRIL 27

7:30 a.m.	Ole Miss Alumni Association Past President's Breakfast	Stardust
8:00	MSMA Reference Committee Breakfast	Atlantic
9:00	MSMA House of Delegates	Crystal/Topaz
	MSMA Art Exhibit (all day)	Caribbean
11:00	Auxiliary Board Meeting	Pacific
11:45	MFMC Committee on Long Term Care Luncheon	Stardust
12:00 noon	Miss. Society of Plastic and Reconstructive Surgery Luncheon	Atlantic
1:00 p.m.	Miss. Foundation for Medical Care Annual Membership Meeting	Crystal/Topaz
1:30	Miss. Gastrointestinal Society Seminar	Sands
2:15	MSMA Reference Committee on Reports of Officers, Board of Trustees, and Counells	Crystal/Topaz
3:30	MSMA Reference Committee on Constitution and Bylaws	Pacific
4:30	Miss. Foundation for Medical Care Board of Directors Meeting	Sands
5:30-7:00	Tennessee Medical Alumni Reception	Stardust
7:00	Ole Miss Medical Alumni Poolside Jamboree	Royal D'Iberville

TUESDAY, APRIL 28

7:00 a.m.	Deep Sea Fishing Rodeo (all day)	Broadwater Marina
	American College of Surgeons, Miss. Chapter Officers Breakfast	Pacific
7:30	MSMA Jail Health Project Advisory Committee Breakfast	Atlantic

7:30 a.m.	Ole Miss Medical Alumni Breakfast Meeting	Stardust
8:00	Association of American Physicians and Surgeons, Miss. Chapter Continental Breakfast	Sands
8:30	MSMA Scientific Session — Section on Medicine	Emerald
9:00	American College of Surgeons, Miss. Chapter Meeting and Program	Crystal
	Auxiliary General Session	Dunes
	MSMA Art Exhibit (all day)	Caribbean
12:00 noon	Auxiliary Luncheon	Topaz
	Flying Physicians Association, Miss. Chapter Luncheon	Atlantic
	Miss. Society of Internal Medicine Luncheon	Stardust
12:30 p.m.	American College of Surgeons, Miss. Chapter Luncheon	Crystal
1:00	Miss. Urological Society Business Meeting	Sands
	Golf Tournament	Broadwater Seacourse
2:00	MSMA Scientific Session — Section on Urology	Sands
	MSMA Scientific Session — Section on Preventive Medicine	Dunes
	MSMA Scientific Session — Section on Surgery	Emerald
	Tennis Tournament	Hilton Court
3:30	Auxiliary Board Meeting	Pacific
5:30	Tennis Tournament Awards	Sidewalk Cafe
5:30-7:00	Tulane Medical Alumni Reception	Atlantic
6:00	Miss. Urological Society Cocktail Buffet	Stardust
6:30	LSU Medical Alumni Cocktail Buffet	Dunes

WEDNESDAY, APRIL 29

7:00 a.m.	"Meet the Professors" Continental Breakfasts	Stardust/ Sands/Dunes
	Deep Sea Fishing Rodeo (all day)	Broadwater Marina
7:30	Miss. Ob-Gyn Society Executive Committee Breakfast	Atlantic
8:00	MSMA Past Presidents' Breakfast	Pacific
	MSMA Scientific Session — Section on Family Practice	Emerald
8:30	Auxiliary Past Presidents Breakfast	Topaz
9:00	MSMA Art Exhibit (all day)	Caribbean
10:00	Auxiliary Beauty & Health Clinic	Grand Casino
11:00	MSMA Nominating Committee	Dunes
	Miss. Perinatal Association Business Meeting	Atlantic
11:30	Miss. Academy of Family Physicians Luncheon and Program	Crystal
	American Academy of Pediatrics, Miss. Chapter Luncheon	Sands
12:00 noon	MSMA Fifty Year Club Luncheon	Pacific
	Miss. Ob-Gyn Society Luncheon Meeting	Stardust
1:30 p.m.	MSMA Scientific Session — Section on Ob-Gyn	Emerald
2:00	MSMA Scientific Session — Section on Pediatrics	Topaz
6:30	MSMA Membership and Auxiliary Fellowship Party	

THURSDAY, APRIL 30

9:00 a.m.	MSMA House of Delegates	Crystal/Topaz

SCIENTIFIC ASSEMBLY

COUNCIL ON SCIENTIFIC ASSEMBLY

J. Elmer Nix, Chairman



Dr. Nix

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THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations and major medical institutions will present the Scientific Exhibit. Physicians are eligible for the Aesculapius Awards given for excellence of presentation, quality of content, and originality.

EXHIBITS AND AUTHORS

Athletic Injury of the Lower Extremity
Thomas F. Hewes, William C. Hopper and William L. Seidensticker, Gulf Coast Surgical Clinic, Gulfport, MS.

Balloon Angioplasty: Indications and Results in Coronary and Peripheral Vascular Disease
Kenneth Bennett, James Crosthwait, Quinton Dickerson, James Hayes, William Harper, Jeff Hollingsworth, Arthur Jones, George McMullan, Thomas Paine, McKamy Smith and Henry Tyler, Mississippi Heart Institute — St. Dominic's Hospital, Jackson, MS.

Breast Reconstruction
H. C. Ethridge, W. Douglas Godfrey, William O. Bobo, Robert Allen Smith and William H. Wallace, Jackson Plastic Surgery Clinic, Jackson, MS.

Correlation of Non-Invasive Vascular Studies with Angiographic Studies
Lewis E. Hatten and Ralph E. Abraham, Forrest General Hospital Vascular Laboratory, Hattiesburg, MS.

Diagnoses and Surgical Treatment of Ventricular Aneurysm
Martin H. McMullan and Thomas L. Kilgore, Jr., Surgical Clinic, Jackson, MS.

Hospice — Close Care of the Terminally Ill
Edward M. Lowicki, Jackson, MS.

Mississippi Transplant Program
Seshadri Raju, Department of Surgery, University Medical Center, Jackson, MS.

Non-Invasive Examination of the Venous System
Seshadri Raju, Tom K. Billups and James D. Hardy, Division of Vascular Surgery and the Doppler Laboratory, University Medical Center, Jackson, MS.

Surgical Treatment of Morbid Obesity
Jack B. Campbell and Charles E. Farmer, Mississippi Surgical Group, Jackson, MS.
Thumb Reconstruction
William H. Wallace and Robert Allen Smith, Jackson Plastic Surgery Group, Jackson, MS.
Unusual Problems in Pulmonary Surgery
Richard L. Yelverton, Anthony B. Petro and Walter R. Jones, Jr., Lakeland Surgical Clinic, Jackson, MS.

SCIENTIFIC PROGRAM

Program is acceptable for 16 prescribed hours Category I credit toward the AMA Physician's Recognition Award.

SCIENTIFIC PROGRAM
Section on Orthopedic Surgery

Sunday, April 26
8:00 a.m.
Emerald Room

James L. Hughes, Jackson, Chairman


Dr. Hughes

SHORT COURSE IN:

Current State of the Art in External Fixation Techniques
Dana C. Mears, associate professor of orthopedic surgery, University of Pittsburgh, Pittsburgh, PA

SCIENTIFIC PROGRAM
Section on Anesthesiology

Sunday, April 26
9:00 a.m.
Topaz Room

David I. Carlson, Jackson Chairman
Orin F. Guidry, Jackson Secretary


Dr. Carlson

SHORT COURSES IN:

Pregnancy and Hypertension
Patricia Norman, assistant professor of anesthesiology, University of Mississippi School of Medicine, Jackson

Aypokalemia
Dexter C. Nettles, Jackson, MS

Renin-Angiotension
William B. Hulett, Jackson, MS

SCIENTIFIC PROGRAM
Section on EENT

Sunday, April 26
9:00 a.m.
Sands/Stardust Rooms

J. George Smith, Jackson Chairman
W. Joe Burnett, Oxford Secretary


Dr. Smith

SHORT COURSES IN:

Rhinoplasty: Case Presentations
Stardust Room, 9:00 a.m.

Intraocular Lenses: Case Presentations
Sands Room, 9:00 a.m.

Head and Neck Surgery: Case Presentations
Stardust Room, 10:45 a.m.

SCIENTIFIC PROGRAM
Section on Radiology

Sunday, April 26
9:00 a.m.
Dunes Room

Kenneth G. Carter, Jackson Chairman

Sandra A. Rhoden, Jackson Secretary


Dr. Carter

SHORT COURSE IN:

Interventional Biliary Radiology-Retained Stone Removal and Percutaneous Biliary Drainage by the Radiologist
Thomas S. Moore, assistant professor of radiology, University of Mississippi School of Medicine, Jackson

SCIENTIFIC PROGRAM
Section on Dermatology

Sunday, April 26
9:00 a.m.
Pacific Room

Thomas C. Garrott, Biloxi
Chairman
Donald F. Barraza, Natchez
Secretary


Dr. Garrott

SHORT COURSE IN:

Purpura and Vasculitis
William H. Gullung, Hattiesburg, MS

Case Presentations
Members of Mississippi Dermatology Society

SCIENTIFIC PROGRAM
Section on Psychiatry

Sunday, April 26
9:00 a.m.
Atlantic Room

William M. Wood, Gulfport
Chairman
Nan Brantley, Jackson
Secretary


Dr. Wood

SHORT COURSE IN:

Sex and Intimacy
Domeena C. Renshaw, professor and assistant chairman, Department of Psychiatry, Loyola University Stritch School of Medicine and director, Loyola Sexual Dysfunction Clinic, Maywood, IL

SCIENTIFIC PROGRAM
Section on Pathology

Sunday, April 26
9:00 a.m.
Crystal Room

Benella J. Oltremari, Greenville
Chairman
Thomas G. Puckett, Hattiesburg
Secretary


Dr. Oltremari

SHORT COURSES IN:

Bone Marrow Interpretation
Francis Morrison, professor of medicine and director, Division of Hematology, University of Mississippi School of Medicine, Jackson

Diagnostic Problems in Soft Tissue Tumors of Children
Bruce L. Webber, Department of Pathology, St. Jude Children's Research Hospital, Memphis, TN

SCIENTIFIC PROGRAM
Section on Medicine

Tuesday, April 28
8:30 a.m.
Emerald Room

Richard M. Nowell, Jackson
Chairman
Don Q. Mitchell, Jackson
Secretary


Dr. Nowell

SHORT COURSES IN:

Renovascular Hypertension: Evaluation and Treatment
Charles H. Laney, Jackson, MS

Gastrointestinal Tract Bleeding
Robert Lewis Slaughter, professor of medicine, University of Alabama in Birmingham School of Medicine, Birmingham

What's New in Antibiotics
William A. Causey, associate professor of medicine, Veterans Administration Medical Center, Jackson, MS

Advances in Oncology
Martin M. Newcomb, Jackson, MS

SCIENTIFIC PROGRAM
Section on Urology

Tuesday, April 28
2:00 p.m.
Sands Room

Stanley A. Wade, Meridian
Chairman
Ronald L. Brown, Gulfport
Secretary


Dr. Wade

SHORT COURSE IN:

GENITOURINARY MALIGNANCY: CASE PRESENTATIONS

Harry Grabstald, professor and director of urologic oncology, Division of Urology, Department of Surgery, University of Florida College of Medicine, Gainesville

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SCIENTIFIC PROGRAM
Section on Surgery



DR. CRAIG

Tuesday, April 28
2:00 p.m.
Emerald Room

H. Vann Craig, Natchez
Chairman
Jerry R. Adkins, Biloxi
Secretary

SHORT COURSES IN:

ANTIBIOTICS FOR THE SEPTIC HOSPITAL PATIENT
George A. Pankey, head, section on infectious diseases, Ochsner Clinic, New Orleans

INDICATIONS FOR THE FLEXIBLE SIGMOIDOSCOPY
Howard D. Robertson, USAF Medical Center, Keesler Air Force Base, Biloxi

BREAST AND CHEST WALL RECONSTRUCTION
Frederick R. Heckler, associate professor of surgery (plastic) and chief, Division of Plastic Surgery, University of Mississippi School of Medicine, Jackson

DIAGNOSIS AND TREATMENT OF ABDOMINAL AORTIC ANEURYSM
Rodney Y. Wolf, Memphis, TN

SCIENTIFIC PROGRAM
Section on Preventive Medicine



DR. MOORE

Tuesday, April 28
2:00 p.m.
Dunes Room

Steven L. Moore, Jackson
Chairman
Thomas E. Waller, Starkville
Secretary

SHORT COURSES IN:

BUILDING A MODEL FOR COMMUNITY HEALTH CARE
Wilfred R. Gillis, professor and chairman, Department of Family Medicine, University of Mississippi School of Medicine, Jackson

T. Walter Treadwell, professor of family medicine, University of Mississippi School of Medicine, Jackson

PREVENTIVE MEDICINE/PERIODIC HEALTH SCREENING/BIRTH TO DEATH
H. Tom Milhorn, assistant professor (research), Department of Family Medicine, University of Mississippi School of Medicine, Jackson

HYPERTENSION PROBLEM: OFFICE MANAGEMENT
T. D. Lampton, associate professor of medicine, University of Mississippi School of Medicine, Jackson

ROCKY MOUNTAIN SPOTTED FEVER IN MISSISSIPPI
Frank M. Wiygul, assistant professor, Department of Family Medicine, University of Mississippi School of Medicine, Jackson

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SCIENTIFIC PROGRAM
Section on Family Practice



DR. BOWEN

Wednesday, April 29
8:00 a.m.
Emerald Room

Frank W. Bowen, Carthage
Chairman
W. K. Stewart, Pass Christian
Secretary

"Meet the Professor" Breakfasts

7:00 a.m. Stardust	"Diabetes in the Aged" William S. Nicholas Jackson
7:00 a.m. Sands	"Anemias" Dale E. Hammerschmidt Minneapolis, MN
7:00 a.m. Dunes	"Myocardial Ischemia" Allan M. Lefer Philadelphia, PA

SECTION ON FAMILY PRACTICE/Continued

8:00 a.m. James Grant Thompson Memorial Lecture:
PROSTAGLANDINS IN ACUTE INFLAMMATION
Gerald Weissmann, professor of medicine and director, Division of Rheumatology, New York University Medical Center, New York, NY

9:00 a.m. IMMUNE BASES OF ATHEROSCLEROSIS, SHOCK LUNG, AND OTHER DISORDERS
Dale E. Hammerschmidt, assistant professor of medicine, University of Minnesota Hospital, Minneapolis

9:30 a.m. CARDIOVASCULAR ACTIONS OF PROSTAGLANDINS IN THE TREATMENT OF SHOCK
Allan M. Lefer, professor and chairman, Department of Physiology, Jefferson Medical College, Philadelphia, PA

10:00 a.m. PANEL DISCUSSION: Drs. Weissmann, Lefer, Hammerschmidt

10:30 a.m. Break

10:45 a.m. MANAGEMENT OF THE INSULIN DEPENDENT DIABETIC PATIENT
William S. Nicholas, associate professor of medicine, University of Mississippi School of Medicine, Jackson

11:15 a.m. MANAGEMENT OF THE INSULIN INDEPENDENT PATIENT
Dr. Nicholas

First Annual
James Grant Thompson Memorial Lecture

"Prostaglandins in Acute Inflammation"
Gerald Weissmann, New York, NY

Wednesday, April 29
8:00 a.m., Emerald Room

SCIENTIFIC PROGRAM
Section on Ob-Gyn


DR. LIPSCOMB

Wednesday, April 29
1:30 p.m.
Emerald Room

Lewis D. Lipscomb, Jackson
Chairman
W. L. Kahlstorf, Tupelo
Secretary

SHORT COURSES IN:

RESULT OF MCINDOE VAGINOPLASTY FOR CONGENITAL ABSENCE OF VAGINA AND SURGICAL EXCISION OF THE VAGINA
Clifford R. Wheeless, Jr., chief of obstetrics and gynecology, Union Memorial Hospital, Baltimore, MD

MOLAR PREGNANCY UPDATE
John P. Mladineo, Jackson, MS

OVARIAN CANCER: PROBLEMS AND PROGRESS
Richard C. Boronow, Jackson, MS

ANATOMY AND PHYSIOLOGY OF A MEDICAL-LEGAL DILEMMA
Glenn Wegener, Clarksdale, MS

SCIENTIFIC PROGRAM
Section on Pediatrics


DR. WARD

Wednesday, April 29
2:00 p.m.
Topaz Room

Mary J. Ward, Corinth
Chairman
William B. Simmons, Meridian
Secretary

SHORT COURSES IN:

POTPOURRI OF OUTPATIENT INFECTIOUS DISEASE PROBLEMS
Charles M. Ginsburg, director of ambulatory services, Department of Pediatrics, Southwestern Medical School, Dallas, TX

AN ANTIBIOTIC UPDATE
Heinz F. Eichenwald, chairman, Department of Pediatrics, Southwestern Medical School, Dallas, TX

OUT OF STATE ESSAYISTS



GERALD WEISSMANN
New York, NY



DANA C. MEARS
Pittsburgh, PA



BRUCE L. WEBBER
Memphis, TN



DALE E.
HAMMERSCHMIDT
Minneapolis, MN



DOMEENA C. RENSHAW
Maywood, IL



ROBERT LEWIS
SLAUGHTER
Birmingham, AL



RODNEY Y. WOLF
Memphis, TN



HARRY GRABSTALD
Gainesville, FL



HEINZ F. EICHENWALD
Dallas, TX



GEORGE A. PANKEY
New Orleans, LA



ALLAN M. LEFER
Philadelphia, PA



CLIFFORD R. WHEELESS
Baltimore, MD

Photo Not Available — Charles M. Ginsburg, Dallas

SUNDAY, APRIL 26, 1981

MISSISSIPPI DERMATOLOGY SOCIETY

The Mississippi Dermatology Society will hold a breakfast meeting at 7:30 a.m., Sunday, April 26, in the Pacific Room. Thomas C. Garrott of Biloxi is president, and Donald F. Barraza of Natchez is secretary-treasurer and president-elect.

MISSISSIPPI EENT ASSOCIATION

The Mississippi EENT Association will hold a breakfast and business session on Sunday, April 26, at 7:30 a.m. in the Stardust Room. Association officers are: Myron W. Lockey of Jackson, president; John L. Pendergrass of Hattiesburg, vice president; and Wilson E. Moak of Jackson, secretary-treasurer.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGY

The Mississippi Society of Anesthesiology will hold a breakfast meeting on Sunday, April 26, at 8:00 a.m. in the Topaz Room. Society officers are: David I. Carlson of Jackson, president; Orin F. Guidry of Jackson, president-elect; and Betty Miles Bailey of Biloxi, secretary-treasurer.

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

The Mississippi Association of Pathologists will hold a luncheon meeting at 12:00 noon on Sunday, April 26, in the Crystal Room. Benella Oltremari of Greenville is association president; David R. Steckler of Natchez is president-elect; T. G. Puckett of Hattiesburg is secretary; and R. Lamar Burrow, Jr., of McComb is treasurer.

ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

The Academy of Facial Plastic and Reconstructive Surgery will hold a luncheon on Sunday, April 26, at 12:00 noon in the Dunes Room. Academy officers are: Will K. Austin, Jr., of McComb, president; Michael H. Carter, Jr., of Greenwood, vice president; and J. George Smith of Jackson, secretary.

MISSISSIPPI ORTHOPEDIC SOCIETY

The Mississippi Orthopedic Society will hold a luncheon on Sunday, April 26, at 12:30 p.m. in the Emerald Room. Society officers are: James L. Hughes of Jackson, president; George Truett of Jackson, president-elect; Thomas Blake of Laurel, secretary; and W. T. Lamar of Oxford, vice president.

MISSISSIPPI MEDICAL FRATERNAL AND EDUCATIONAL SOCIETY

The Mississippi Medical Fraternal and Educational Society will hold its fourth annual membership meeting on Sunday, April 26, beginning at 3:30 p.m., in the Emerald Room. Guest speaker will be Mrs. Betty Britton, R.N., patient representative at Mississippi Baptist Medical Center. She will discuss "Hospital Liability and the Patient Representative."

PRESIDENT'S RECEPTION

The annual President's Reception for officers, members of MSMA and the Auxiliary and invited guests will be held in the Crystal and Topaz Rooms on Sunday, April 26, from 5:30 to 7:00 p.m.

MONDAY, APRIL 27, 1981

UNIVERSITY OF MISSISSIPPI ALUMNI ASSOCIATION

The University of Mississippi Alumni Association will host a Past Presidents' Breakfast at 7:30 a.m., Monday, April 27, in the Stardust Room.

REFERENCE COMMITTEE BREAKFAST

Members of all reference committees of the House of Delegates will meet at 8:00 a.m. for breakfast and an orientation session on Monday, April 27, in the Atlantic Room. Hosts are Carl G. Evers of Jackson, speaker, and Walter H. Rose of Indianola, vice speaker.

MISSISSIPPI SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

The Mississippi Society of Plastic and Reconstructive Surgery will hold a luncheon meeting on Monday, April 27 at 12:00 noon in the Atlantic Room. Society officers are: H. C. Ethridge of Jackson, president; Michael E. Jabaley of Jackson, vice president; and Robert T. Love of Greenville, secretary.

MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The Mississippi Foundation for Medical Care will hold its annual meeting on Monday, April 27, beginning at 1:00 p.m. in the Crystal and Topaz Rooms. Guest speaker will be Sen. Thad Cochran, who will discuss Washington's view of current health issues. All members are urged to attend.

MISSISSIPPI GASTROINTESTINAL SOCIETY

The Mississippi Gastrointestinal Society will sponsor a seminar on "Diagnostic Approaches to Some Common GI Problems," featuring discussions of dysphagia, jaundice, GI bleeding and chronic diarrhea. The seminar will begin at 1:30 p.m. on Monday, April 27, in the Sands Room. Society officers are James Q. Sones of Jackson, president, and William M. McKell, Jr., of Jackson, secretary.

UNIVERSITY OF TENNESSEE MEDICAL ALUMNI

Medical graduates of the University of Tennessee will be feted at a reception from 5:30-7:00 p.m. on Monday, April 27, in the Stardust Room.

OLE MISS MEDICAL ALUMNI

Alumni registration will be located adjacent to MSMA general registration on the First Level Lobby near the Grand Ballroom, and will be open at 8:00 a.m. Tickets for the evening party will be available. A cocktail party and seafood jamboree will be held Monday, April 27 at the Royal D'Iberville Hotel, beginning at 7:00 p.m. A business meeting and continental breakfast will be held Tuesday, April 28, beginning at 7:30 a.m. in the Stardust Room at the Biloxi Hilton.

TUESDAY, APRIL 28, 1981

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The American College of Surgeons, Mississippi Chapter, will conduct a scientific meeting at 9:00 a.m. on Tuesday, April 28, in the Crystal Room.

Guest speaker will be Dr. Harry Grabstald, professor and director of urologic oncology of the University of Florida College of Medicine. His topic will be "Role of Lymphadenectomy in the Surgical Management of Cancer." Fellows will assemble for luncheon in the Crystal Room at 12:30 p.m. Officers of the chapter are: W. Lamar Weems of Jackson, president; Whitman B. Johnson, Jr., of Clarksdale, president-elect; and Benton M. Hilbun of Tupelo, secretary-treasurer. An officers' breakfast will be held in the Pacific Room at 7:00 a.m.

MSMA JAIL HEALTH PROJECT ADVISORY COMMITTEE

The MSMA Jail Health Project Advisory Committee will hold a breakfast meeting on Tuesday, April 28, at 7:30 a.m. in the Atlantic Room.

MISSISSIPPI CHAPTER, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

All physicians are invited to attend a breakfast meeting at 8:00 a.m., Tuesday, April 27 in the Sands Room. Curtis Caine of Jackson, national president of the association, is in charge of arrangements.

FLYING PHYSICIANS ASSOCIATION, MISSISSIPPI CHAPTER

The Mississippi Chapter of the Flying Physicians Association, Inc., will host a luncheon in the Atlantic Room on Tuesday, April 28, beginning at 12:00 noon. James B. Martin of Ocean Springs is president and Thomas R. Singley of Pascagoula is secretary-treasurer.

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

The Mississippi Society of Internal Medicine will hold a luncheon at 12:00 noon on Tuesday, April 28, in the Stardust Room. Society officers are Bruce E. Atkinson of Amory, president and W. Mack Gorton, Belzoni, secretary-treasurer.

MISSISSIPPI UROLOGICAL SOCIETY

The Mississippi Urological Society will hold a business meeting at 1:00 p.m. on Tuesday, April 28 in the Sands Room. They will also host a cocktail buffet beginning at 6:00 p.m. in the Stardust Room. Society officers are: Stanley Wade of Meridian, president; Robert F. Carter of Biloxi, president-elect; and Ronald L. Brown of Gulfport, secretary-treasurer.

MSMA GOLF TOURNAMENT

The golf tournament, sponsored by South Central Bell, will begin at 1:00 on Tuesday afternoon, April 28.

MSMA TENNIS TOURNAMENT

The MSMA tennis tournament, sponsored by the Mississippi Medical Fraternal and Educational Society, will begin at 2:00 p.m. on Tuesday, April 28. James O. Manning of Jackson is chairman.

MSMA FISHING RODEO

The MSMA Fishing Rodeo will begin at 7:00 a.m. on Tuesday, April 28 and Wednesday, April 29. Boats will leave from the Broadwater Marina and return at 3:30 p.m.

TULANE MEDICAL ALUMNI ASSOCIATION

The Tulane Medical Alumni will sponsor a reception for alumni, faculty and guests, beginning at 5:30 p.m. on Tuesday, April 28. Miss Lou Johnson, director of Tulane Medical Alumni Association, is in charge of arrangements.

LSU MEDICAL ALUMNI ASSOCIATION

LSU Medical Alumni Association will host a cocktail buffet beginning at 6:30 p.m. on Tuesday, April 28, in the Dunes Room. Roland Sampson of Jackson is in charge of arrangements.

WEDNESDAY, APRIL 29

MISSISSIPPI PERINATAL ASSOCIATION

The Mississippi Perinatal Association will hold a business meeting at 11:00 a.m. on Wednesday, April 29, in the Atlantic Room. Officers are: Dan Draughn of Jackson, president; Rodney Meeks of Jackson, vice president; and Frank Wilburn of Tupelo, secretary-treasurer.

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS

The Mississippi Academy of Family Physicians will conduct a luncheon meeting at 11:30 a.m., Wednesday, April 29, in the Crystal Room. Guest speaker will be Thomas E. Weiss of Ochsner Clinic, New Orleans. His topic will be "Current Concepts in the Therapy of Common Arthritic Conditions." Officers of the Mississippi Academy are: J. Edward Hill of Hollandale, president; Ben E. Kitchens of Iuka, president-elect; Louis Rubenstein of Ocean Springs, vice-president; and Hardy B. Woodbridge, Jr., of Jackson, secretary-treasurer.

AMERICAN ACADEMY OF PEDIATRICS, MISSISSIPPI CHAPTER

The Mississippi Chapter of the American Academy of Pediatrics will host a luncheon meeting on Wednesday, April 29, at 11:30 a.m., in the Sands Room. David Watson of Jackson is chapter president; Shelby Smith of McComb is vice-president; and Robert Buckley, Jr., of Columbus is secretary-treasurer.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century-plus members at a special luncheon on Wednesday, April 29, at 12:00 noon in the Pacific Room. Sidney O. Graves of Natchez, chairman of the board, will preside.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Wednesday, April 29, at 12:00 noon in the Stardust Room. Society officers are: Thomas R. Singley of Pascagoula, president; Fred Ingram of Jackson, vice-president; and Earl T. Stubblefield of Jackson, secretary-treasurer. The Society will also hold a breakfast meeting for the executive committee at 7:30 a.m. on Wednesday.

MSMA MEMBERSHIP AND AUXILIARY FELLOWSHIP PARTY

A fellowship hour for all MSMA members, spouses and guests will be held Wednesday evening, April 29, beginning at 6:30 p.m. Tickets will be available at MSMA registration.

MISSISSIPPI STATE MEDICAL ASSOCIATION AUXILIARY

58th Annual Session **Biloxi Hilton**
April 26-30, 1981

OFFICERS

President
Mrs. Curtis D. Roberts, Brandon

President-Elect
Mrs. John Estess, Hollandale

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Mrs. James Martin, Ocean Springs

Second Vice-President
Mrs. Stanley Hartness, Kosciusko

Third Vice-President
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Mrs. Stewart Williford, Hattiesburg

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Mrs. Joe Herrington, Natchez

Parliamentarian
Mrs. Ralph Sneed, Jackson



Mrs. Roberts
President



Mrs. Estess
President-Elect

ACTIVITIES CALENDAR

Sunday, April 26

9:00 a.m. Registration — First Level Lobby

4:00 p.m. Hospitality Center
Boutique Booth

Monday, April 27

9:00 a.m. MSMA House of Delegates — Crystal/Topaz

11:00 Preconvention Board Meeting — Pacific

7:00 p.m. Ole Miss Medical Alumni Seafood Jamboree — Royal D'Iberville

Tuesday, April 28

9:00 a.m. General Session — Dunes
Invocation
Welcome
Introductions
Memorial
Roll Call
Minutes
Reports
Appointment of Delegates to AMA Auxiliary Convention
Speakers
Mrs. John G. Bates, 1st Vice-President, AMA Auxiliary
Mrs. Charles A. Prater, President Southern Medical Auxiliary
Business and Awards
Election and Installation of Officers
Courtesy Resolutions
Adjournment

12:00 noon Social Hour, Luncheon and Fashion Show — Topaz
Invocation
Presentation of County Presidents
Introductions
Greetings
Dr. Paul H. Moore, MSMA President
Presentation of 1981 President
Fashion Show

3:00 Postconvention Board Meeting — Pacific

Wednesday, April 29

8:30 a.m. Past Presidents' Breakfast — Pacific

10:00 Beauty and Health Program — Grand Casino
Jill Cury, Director
Toni Beck, Exercise Supervisor
Greenhouse Health & Beauty Resort
Arlington, TX

6:30 p.m. MSMA Membership and Auxiliary Party

Thursday, April 30

9:00 a.m. MSMA House of Delegates — Crystal/Topaz

REGISTRATION INFORMATION

The registration desk and Hospitality Center for the 58th Annual Session of the MSMA Auxiliary well be located on the First Level Lobby near the Grand Ballroom. Hours of registration will be:

Sunday, April 26 — 9:00 a.m.-4:00 p.m.
Monday, April 27 — 9:00 a.m.-4:00 p.m.
Tuesday, April 28 — 8:30 a.m.-9:30 a.m.

Hospitality Center hours will be 10:00 a.m.-4:00 p.m. daily.

BOUTIQUE BOOTH

A collection of hand-made articles and crafts will be offered for sale. The proceeds will go to the AMA-ERF, and credit will be issued for each auxiliary toward the AMA-ERF Award.

ART EXHIBIT

An exhibit of art works by MSMA and MSMA Auxiliary members will be on display each day beginning at 9:00 a.m. on Monday April 27. The exhibit will be located in the Caribbean Room. Judi Betts, well-known artist and instructor from Baton Rouge, will judge the works and present first, second and third place awards.

COMMITTEE CHAIRMEN

Convention Chairman
Mrs. R. Faser Triplett, Jackson

Convention Co-Chairman
Mrs. Alvin E. Brent, Jr., Jackson

Registration
Mrs. Floyd L. Lummus, Tupelo

Hospitality Center
Mrs. James Martin, Ocean Springs

Luncheon
Mrs. Carl Evers, Jackson

Boutique Booth
Mrs. Terrell Blanton, Jackson

Publicity
Mrs. I. C. Knox, Jr., Vicksburg

Getting the Most from Your Collection Agency

Some patients who can pay you, won't pay you . . . that's a fact. In fairness to those patients who make an effort to pay you for your services, something must be and should be done about the first group.

A collection agency might be the answer . . . especially if your office staff does a good job on following up on overdue accounts. After repeated contacts and requests to pay, turning "won't pay" patients over may be your best alternative.

We recommend selecting an agency that has had experience in collecting for physicians, dentists, and hospitals. Checking agency references is a must. Then your next step is being sure that your staff cooperates with the agency in the four ways we've outlined.

1. *Use a good "patient history" form.* It will help your staff and your collection agency to do a better job on delinquent accounts. At the very least, you'll need the patient's (or responsible person's) name, full address, phone number, marital status, birthdate, employer, employer's address and phone number, the name of the person or physician who referred the patient, and full insurance information. If the patient is married you should ask for the same information on the spouse, and remember to have patients fill out a new form periodically — annually is recommended. Today, name, marital status, and jobs change with great frequency.

2. *Keep good records.* This means your staff should record all written or telephone contacts with a patient as they try to collect. Share the record of your efforts with the collection agency. *Never* bill or contact the patient after turning the account over.

3. *Turn accounts over on a regular, monthly basis.* If a patient hasn't responded to repeated billing and contacts from your office after a period of time — take action. Medical accounts should be given to a professional collector after 120 or 180 days. Many physicians wait too long — as long as a year or two, making it almost impossible for even the agency to do its job. "Aging" your accounts will help you determine which ones to refer. Your accountant can show your staff how to do this.

4. *Don't ask for "progress reports."* Repeated calls by your staff for information about the status of delinquent accounts isn't a good idea. Agency personnel are busy "reporting" when they should be "collecting.

Do remember that an effective in-office collection system is a must. Give your staff your guidance and support in this area.

One word of caution. If your account followup indicates the patient's refusal to pay is based on dissatisfaction with the service, review the account carefully before turning it over to a collection agency. A malpractice suit can be triggered by collection enforcement of an account of a patient with a substantive grievance.

(Editor's Note: This month's article was prepared by Karen Zupko of the AMA's Department of Practice Management. Please direct your practice management inquiries to Bucky Murphy, P.O. Box 5229, Jackson, MS 39216.)

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Senator Cochran Will Speak During MSMA Annual Session

Senator Thad Cochran will address the annual meeting of the Mississippi Foundation for Medical Care, which will be held later this month in conjunction with MSMA's 113th Annual Session. The meeting is scheduled for 1:00 p.m., Monday, April 27, at the Biloxi Hilton.



Sen. Cochran

Senator Cochran will discuss Washington's view of current health care issues.

Cochran's election to the U.S. Senate in 1978, replacing James O. Eastland, marked the first time in over 100 years a Republican was elected to statewide office in Mississippi. In the Senate he serves on the Agriculture and Appropriations Committee. During the 97th Congress he is serving as chairman of the Production, Marketing and Price Stabilization Subcommittee of Agriculture, and as chairman of the Agricultural Subcommittee of Appropriations.

A native of Pontotoc, Senator Cochran received his B.A. and law degrees from the University of Mississippi. He served in the U.S. Navy, and studied international law for a year at the University of Dublin, Ireland, under a Rotary Foundation Fellowship. For seven years, he practiced law in Jackson, MS. He was president of the Young Lawyers Section of the Mississippi State Bar, and in 1971 he was named one of the three outstanding young men of the year in the state. He served three terms in the U.S. House of Representatives before being elected to the Senate.

Ole Miss Medical Alumni Will Meet This Month

The annual reunion of University of Mississippi medical alumni will take place during MSMA's upcoming 113th Annual Session in Biloxi.

Medical alumni, their families and guests will meet for a cocktail party and seafood jamboree beginning at 7:00 p.m. on Monday, April 27, in the Versailles Room of the Royal D'Iberville Hotel. Sponsors of the annual event and their representatives are: Berlex Laboratories — Fred Mann, David Flanagan and John Harris; Bristol Laboratories — Bill Vaughn; Foster Meidcal Corp. — Bud Keirn and David McNamara; McNeil Pharmaceutical — John Scott; Pfizer Pharmaceuticals — Wayne Burke; and Thomas Yates and Company — Thomas Yates. Dr. Leonard D. Ball of Gulfport is chairman of program planning.

The Medical Alumni Chapter business meeting will be held at the Biloxi Hilton on Tuesday, April 28, beginning with a continental breakfast at 7:30 a.m. in the Stardust Room. Chapter president is Dr. Thomas R. Singley of Pascagoula.

Ole Miss Guardian Society Day will be conducted on Sunday, April 26 at the Royal D'Iberville Hotel. A business meeting at 10:00 a.m. in the Beauvoir Room will be followed by a brunch at 11:30 a.m. in the Versailles Room. Dr. Joseph Johnston of Mount Olive is president of the society and Dr. James C. Waits of Laurel is vice-president. Members of the Guardian Society planning committees are: Dr. Bryan Barksdale, Dr. J. Dan Mitchell and Mrs. Carl G. Evers, all of Jackson; and Dr. George Abraham of Vicksburg, chairman.

Plan to Attend

113th Annual Session

April 26-30, 1981

Biloxi Hilton

Medical Licensure Board Increases Registration Fee

By action of the Mississippi State Board of Medical Licensure, the annual reregistration fee for medical licensure has been increased from $30 to $50, effective with the 1981-82 reregistration period.

Executive Officer Frank J. Morgan, Jr., M.D., noted that the self-sustaining Board operates on fees alone — without local, state or federal appropriations.

Authorized by the 1980 Mississippi State Legislature and in operation since July 1, 1980, the State Board of Medical Licensure licenses and sets policies and professional standards of practice for physicians, osteopaths, and podiatrists; conducts exams and considers applications for licensure; investigates alleged violations of the Medical Practice Act; and considers disciplinary action. Dr. Morgan is serving a six-year term as executive officer.

"Art of Healing" Exhibit Opens This Month in Jackson

"The Art of Healing: Medicine and Science in American Art" opens April 10 at the Mississippi Museum of Art in Jackson. The exhibit brings together three centuries of American art dealing with the science of medicine.

Approximately 50 works make up the exhibit, which includes such paintings as Winslow Homer's "Surgeon at Work at the Rear During an Engagement," a 1962 work; George Catlin's "Blue Medicine: A Medicine Man of the Ting-ta-to-ah Band" from 1835; and Norman Rockwell's "The Oculist" from 1956.

Local physicians and medical-related organizations are sponsoring the exhibit in this area. "The Art of Healing" is the first collection of its kind, and was organized by the Birmingham Museum of Art.

The collection can be seen through June 7 during the Museum's gallery hours: Fridays from 10:00 a.m. to 8:00 p.m.; other days, including Sundays, from 10:00 a.m. to 5:00 p.m. The gallery is closed on Mondays.

The Museum welcomes special tours. Arrangements, including lunch at The Palette Restaurant on Tuesdays through Fridays, can be made by calling (601) 960-1515.

CYCLAPEN-W® (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
Otitis media caused by S. pneumoniae (formerly D. pneumoniae) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d	50 mg./kg./day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg./kg./day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg./kg./day†
Skin & Skin *Structures*	250 mg to 500 mg q.i.d.†	50 to 100 mg./kg./day†
Urinary *Tract*	500 mg q.i.d	100 mg./kg./day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

Wyeth Laboratories
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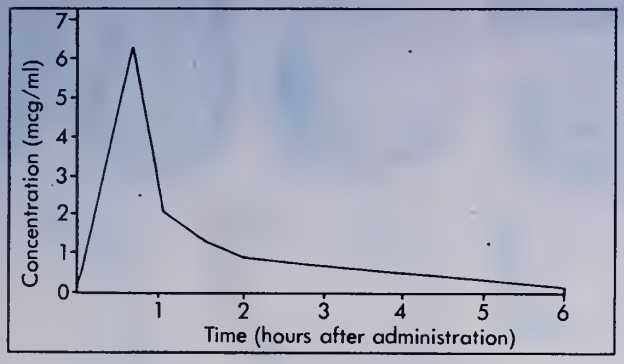
Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*



Less rash, less diarrhea than with ampicillin in studies to date.

Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

High Cure Rates with CYCLAPEN®-W (cyclacillin)		
Causative Organism	Branchitis/Pneumania†	No. of Patients
S. pneumaniae	100% / 95%	73
Chranic Branchitis† (acute exacerbatian)		
H. influenzae	92% — Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.	12
Streptacaccal Sare Thraat†		
Graup A beta-hemalytic Streptacaccus	100% / 86%	44
% Clinical Respanse % Bacterial Eradicatian		

†Due to susceptible organisms.

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*Based an single aral dases af 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data an file, Wyeth Labarataries.

See important information on facing page.

Wyeth Laboratories • Philadelphia, Pa 19101

CYCLAPEN®-W

(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW NAME

POSTGRADUATE CALENDAR

April 21-22, 1981
HEMATOLOGY UPDATE: NEOPLASTIC DISORDERS
University Medical Center, Jackson

Sponsors are the University of Mississippi School of Medicine Department of Medicine Division of Hematology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Francis S. Morrison, M.D., professor of medicine and director of the division of hematology, University of Mississippi School of Medicine.

This program is designed for primary care physicians and will provide practical information on the modern approach to management and supportive care of patients with hematologic neoplastic disorders. Emphasis is on recent advances in management of leukemia and lymphoma which have resulted in a higher rate of cure. Fee: $40. Credit: 6.5 credit hours (.65 CEU), Category I of the Physician's Recognition Award, AMA.

May 2-3, 1981
CLINICAL NUCLEAR MEDICINE IMAGING
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Radiology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: C. Jay Kees, III, M.D., clinical instructor in radiology, University of Mississippi School of Medicine.

This program will include sessions on application of nuclear medicine in abdominal disease and procedures in oncology, nuclear medicine brain imaging in the era of CT and thyroid diagnosis and treatment. Fee: $50 for physicians and scientist members of the Mississippi Society of Nuclear Medicine ($60 for nonmembers). Credit: 8 contact hours (.8 CEU), Category I of the Physician's Recognition Award, AMA.

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

PERSONALS

JAMES ACHORD of UMC attended a recent executive committee meeting of the American College of Gastroenterology in Portchester, NY.

PATRICK BARRETT of Jackson spoke at a recent Indianola Civic League educational workshop on scoliosis.

Columbus Children's Clinic, P.A. (ROBERT L. BUCKLEY, JR. and JACOB SKIWSKI) announce their relocation to Doctor's Park, 425 Hospital Drive, Columbus.

BENJAMIN L. CRAWFORD, III, has associated with the Doctors Clinic of Tylertown for the practice of gynecology.

C. MIMS EDWARDS of Jackson announces the reopening of his office for the practice of psychiatry at 1855 Lakeland Drive.

JOHN E. GREEN of Hattiesburg recently attended a Miami Eye Foundation course on cataract extraction and intraocular lens implantation.

JAMES D. HARDY of UMC recently attended an executive committee meeting of the International Society of Surgery in Basle, Switzerland and presented a paper at the Southern Association for Vascular Surgery in Dorado Beach, Puerto Rico.

MARK H. LEIFER of Meridian has been certified as a diplomate by the American Board of Internal Medicine.

JOHN C. MORRISON of UMC was guest speaker at a recent Southern Perinatal Association meeting in New Orleans.

EDWARD R. NORTH of Jackson recently received the "Book of Golden Deeds" award from the Exchange Club of North Jackson.

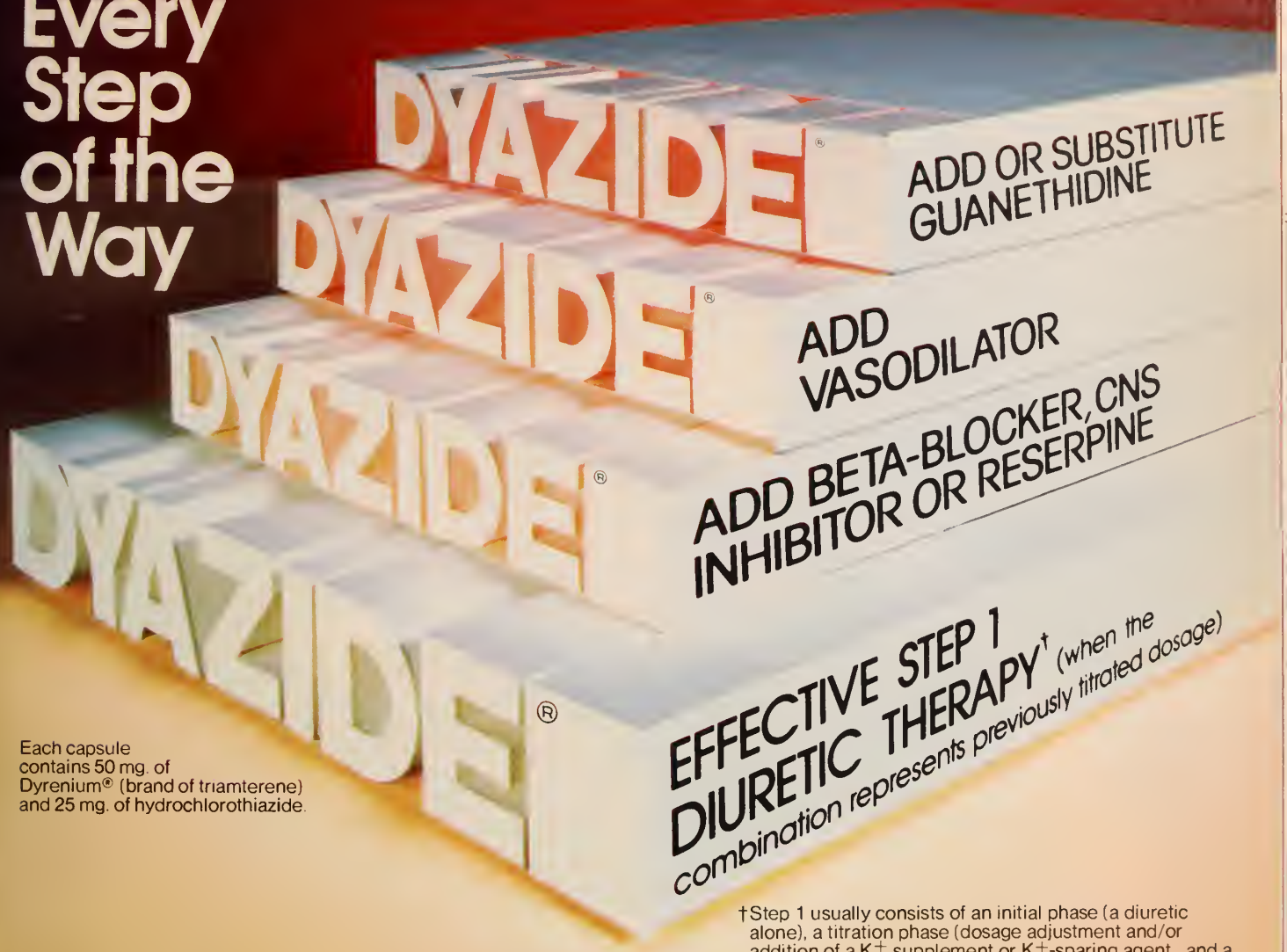
JOHN L. PENDERGRASS of Hattiesburg attended the recent Cataract Microsurgical Course sponsored by the LSU Eye Center in New Orleans.

CHARLES R. SECREST of Houston announces the relocation of his office for the practice of cardiology and internal medicine to Medical Plaza, 1002 East Madison.

ELTON S. THOMAS of Columbus announces the relocation of his office for the practice of general surgery to 428 Hospital Drive.

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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Carolina, P.R. 00630

Motrin® vs aspirin w/codeine...
(ibuprofen)

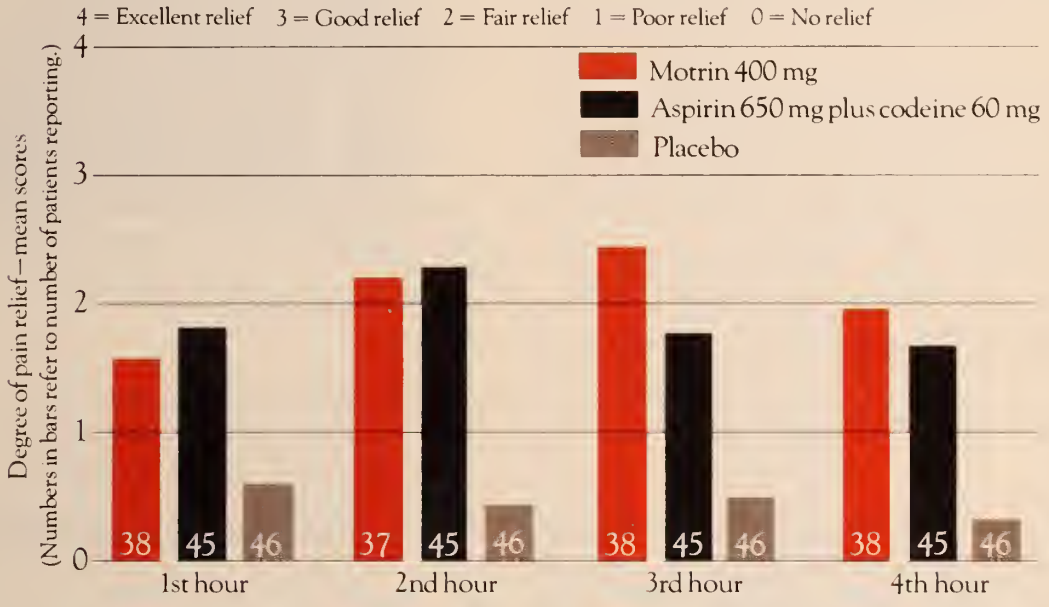


©1981 The Upjohn Company

compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-4-S

J-8260-4

MARCH 1981

WHY I'M A UNITED WAY VOLUNTEER



STEPHEN GRAHAM

Home: Seattle, Washington

Career: Attorney

Age: 29

Married: One daughter

Interests: Hiking, writing, cartooning, bicycling and volunteering for United Way

"Because there's more to my life than just me.

"Like being with my family. Hiking along the timberline. And getting involved in my community.

"Volunteering for United Way adds another dimension to my life. I'm putting my skills to work for the benefit of the entire community. And I'm meeting all kinds of people who are doing the same.

"Most important of all, I'm learning more about human care needs. And how—as a United Way volunteer—I can make a difference here in Seattle. It's a valuable lesson in leadership.

"By helping shape my community's future, through United Way, I'm more than just living my life. I'm fulfilling it."

Thanks to you... it works... for ALL OF US

United Way

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NEW MEMBERS

Butts, Donald Hal, Jackson. Born Winona, MS, July 9, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; neurology residency, same, 1977-80; elected by Central Medical Society.

Davis, Jacqueline D., Natchez. Born Mound Bayou, MS, Oct. 9, 1951; M.D., Meharry Medical College School of Medicine, Nashville, TN, 1975; interned Hurley Medical Center, Flint, MI, one year; ob-gyn residency, Province Hospital, Southfield, MI, 1976-1979; elected by Homochitto Valley Medical Society.

Ford, John Robert, Vicksburg. Born Hazlehurst, MS, Sept. 19, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and family medicine residency, University Medical Center, Jackson, 1976-79; elected by West Mississippi Medical Society.

Gibson, Don Albert, Brandon. Born Jackson, MS, June 1, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and family practice residency. University Medical Center, Jackson, 1976-79; elected by Central Medical Society.

Nichols, Aubrey Norwood, III, Centreville. Born Yazoo, MS, June 17, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned Baptist Memorial Hospital, Memphis, one year; ophthalmology residency, University Medical Center, Jackson, 1977-80; elected by Amite-Wilkinson Counties Medical Society.

Sherman, Bernadette E., Natchez. Born Alcorn County, Oct. 13, 1947; M.D., Meharry Medical College School of Medicine, Nashville, TN, 1976; interned and ob-gyn residency, Providence Hospital, Southfield, MI, 1976-80; elected by Homochitto Valley Medical Society.

Streiffer, Richard H., Collins. Born New Orleans, LA, Feb. 5, 1952; M.D., Louisiana State University School of Medicine, New Orleans, 1977; interned and family practice residency, University of Alabama Medical Center, Tuscaloosa, 1977-80; elected by South Mississippi Medical Society.

Walker, William Edward, Collins. Born Aransas Pass, TX, Nov. 4, 1952; M.D., University of Mississippi Medical Center, Jackson, 1977; interned and family practice residency, University of Alabama Medical Center, Tuscaloosa 1977-80; elected by South Mississippi Medical Society.

DEATHS

Van Landingham, David J., Jackson. Born West Point, MS, May 13, 1913; M.D., University of Tennessee College of Medicine, Memphis 1937; interned Waterbury General Hospital, Waterbury, CT, one year and interned in pathology, John Gaston Hospital, Memphis, 1945-46; internal medicine residency, same, 1946-48; internal medicine residency, Peter Brent Brigham Hospital, Boston, MA, 1948-49 and 3-month fellowship in medicine, Lahey Clinic, Boston; died March 1, 1981, age 67.



Tennis
Deep Sea Fishing
Golf

These tournaments are just a few of the special activities on the schedule for MSMA's 113th Annual Session.

Plan Now To Attend!

MSMA and MMFES Sponsor Seminar to Examine the Medical Malpractice Problem

When Dr. Robert S. Brittain was asked to chair a Colorado Medical Society panel to review malpractice cases, he found he had to re-define his thinking about the real source of the malpractice problem. He shared those thoughts with physicians attending the recent MSMA/MMFES-sponsored malpractice seminar in Jackson.

Speaking on the topic of risk management, the Colorado surgeon remarked that after reviewing 360 cases, the CMS panel found that when their carrier lost medical malpractice suits, it was because of the doctors involved — not the previously identified "villains" — bad laws favoring the public, bad juries, unscrupulous plaintiffs' attorneys, insurance carriers bent on "ripping off" the doctor, and an avaricious public. He outlined measures physicians can take to stop contributing to the malpractice problem.

Dr. Brittain noted that statistics indicate that two-thirds of practicing doctors will not be sued in the next ten years. Of the one-third who do face lawsuits, only one-half will be involved in cases having any merit; and less than one in ten of the cases with merit will be due to "gross negligence."

Turning to the remainder of the cases, Dr. Brittain explored the reasons why suits would be filed. The major cause, he said, is that the patient is angry. He pointed out that the physician's own attitude is often the reason for that anger. A physician's arrogance, displayed by such things as keeping patients waiting or "talking down" to patients, can produce anger, as can what Dr. Brittain termed "unconscionable" bills for services. One such bill, he said, would be to charge for correcting an error which should not have happened in the first place. Another contributing factor is professional jousting — by both doctors and nurses. Disapproval of another doctor's treatment, even demonstrated in such a subtle way as a raised eyebrow, can make a patient angry.

"Change yourselves . . . you can't solve the medical malpractice problem by changing carriers, changing laws, or changing the public."





Dr. C. G. Sutherland of Jackson, standing, moderated a panel discussion during the recent malpractice seminar held in Jackson under the sponsorship of MSMA and the Mississippi Medical Fraternal and Educational Society. Participants included, from left, Dr. Robert S. Brittain of Denver, CO, who discussed "Risk Management – the Do's and Don'ts of Medical Practice"; Dr. Glenn Wegener of Clarksdale, who presented "The Anatomy and Physiology of a Medical-Legal Dilemma"; attorney William Liston of Winona, who outlined "Pertinent Considerations in Undertaking the Prosecution of Medical Negligence Claims"; Judge Andrew Baker of Charleston, who presented "A View of the Physician from the Bench"; and attorney Thomas L. Stennis of Gulfport, who described "The Role of the Defense Lawyer in a Medical Malpractice Action."

Often, surprise is another reason a patient files a claim. This, Dr. Brittain observed, suggests that patients often sign "informed consent" forms without fully understanding them. He reminded physicians that it is not the *form* which is important, but the *informed,* and he illustrated that importance by citing the fact that one-third of patients go to plaintiffs' attorneys because of problems with informed consent. They are simply surprised at the results, in spite of having signed a form.

Dr. Brittain stressed the importance of maintaining adequate and legible medical records and noted that failure to do so often is a contributing factor when cases are lost.

Although he had some advice for physicians who have had a complaint lodged against them (such as being thoroughly prepared to give a deposition and heeding their attorney's advice on being a witness), he emphasized the importance of prevention. He challenged physicians to "change yourselves . . . you can't solve the medical malpractice problem by changing carriers, changing laws or changing the public."



Dr. Robert Brittain advised physicians on Risk Management.

Success Reported For MSMA Legislation

As the 1981 regular Session of the Mississippi Legislature nears an end, MSMA-sponsored bills appear to be in excellent shape. The State Medical Examiner bill (SB-2004) passed both chambers in different forms and was sent to conference. Also in conference after passing both chambers is a bill to increase the per diem paid to hospitals for furnishing care to indigents. A third MSMA bill in conference is HB-743, which would reduce the blood alcohol content for D.W.I.

The Uniform Determination of Death Act (SB-2203) was adopted by both chambers and has gone to the Governor for his signature. The passage of this act makes Mississippi the first state to adopt this model bill. A bill which would reduce retention time for X-rays from seven to four years has passed both chambers with only minor differences. The Senate is expected to concur with House amendments, thus sending the bill to the Governor.

The association's participation in the legislative session has not been limited to vigorous efforts to gain support of MSMA-sponsored legislation, however. For the 17th consecutive year, the association's Emergency Medical Care Unit, staffed by Mavis Barlow, R.N., and volunteer Doctors of the Day, has provided medical services to legislators and Capitol employees. The MSMA Auxiliary again held its ''Legislative Day'' in Jackson. The occasion included a visit to the Capitol and a luncheon at the Holiday Inn Downtown, with Mississippi legislators as special guests.



Rep. Cecil Simmons attended the luncheon in the unique role of legislative guest and auxiliary member. He is married to Dr. Sue Simmons of Maben.



Bucky Murphy, at left, MSMA assistant executive secretary and general counsel, welcomed guests to the Legislative Day luncheon. Among those seated at the head table were, from right, Sen. Wayne Burkes of Bolton, Mrs. Brad Dye and Lt. Gov. Dye of Jackson, and Mrs. Curtis Roberts of Brandon, auxiliary president.



Sen. Vince Scoper of Laurel, left, and Rep. Johnny Stringer of Bay Springs were among guests at MSMA Auxiliary's Legislative Day luncheon.



Sen. Tommy Brooks of Carthage, at right, introduced Dr. Arthur A. Derrick of Durant, left, to the Mississippi Senate. Dr. Derrick is among the volunteer Doctors of the Day who have staffed the association's Emergency Medical Care Unit during the legislative session.

In G.I. therapy



Adjunctive Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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"We're together because Dr. Benson recommended home health care."

Home health care is an excellent alternative when your patients cannot fully care for themselves, yet do not need to be in a hospital or nursing home. They can enjoy the comforts of home and family while receiving the care they need, often at a cost far below that of institutional care. And you are always in full control of the plan of care.

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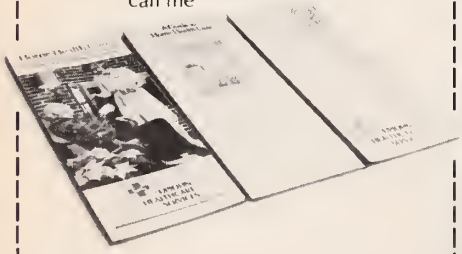


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Please ☐ send me 10 free home health care information packets
☐ have your service director call me



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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 7-11, 1981, Chicago; James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 113th Annual Session, April 26-30, 1981, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 29-August 1, 1981, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Howard Memorial Hospital
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
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Pascagoula, MS 39567

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GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

SURGEON to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

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PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

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IN CONCLUSION

The relative health of women will decline as they increasingly enter the workplace, says an article in published proceedings of an Occupational Safety and Health Symposium conducted by the AMA and the National Institute for Occupational Safety and Health. Exposure to environmental risks is increasing for working women, as is exposure to job stress, which is compounded by the strain of home responsibilities. Lack of exercise (women average six fewer hours of free time for exercise per week), overeating, drinking, and smoking are also contributing factors.

Veterans using the VA hospitals tend to be older, in poor health, of lower income, and lacking in health insurance, says a report in the March 13 JAMA. Younger and more affluent veterans are more likely to use community health resources rather than VA facilities. The study, conducted to determine the need for routine admission chest x-rays, concluded that routine screening in VA hospitals should be continued. More than 90% of those in the study were 40 years of age or older, and many suffered from health problems of the heart or lungs.

About 75% of the 3½ million women giving birth each year in the U.S. begin prenatal care within three months of pregnancy, and the AMA's Committee on Maternal, Adolescent and Child Health has called for an all-out national effort on the part of physicians, government and the public to extend that care to the remaining women. The committee recommended the consolidation of federal programs dealing with maternal and child health, adequate funding of Medicaid and other programs to help pregnant women, and increased public education on the importance of prenatal care.

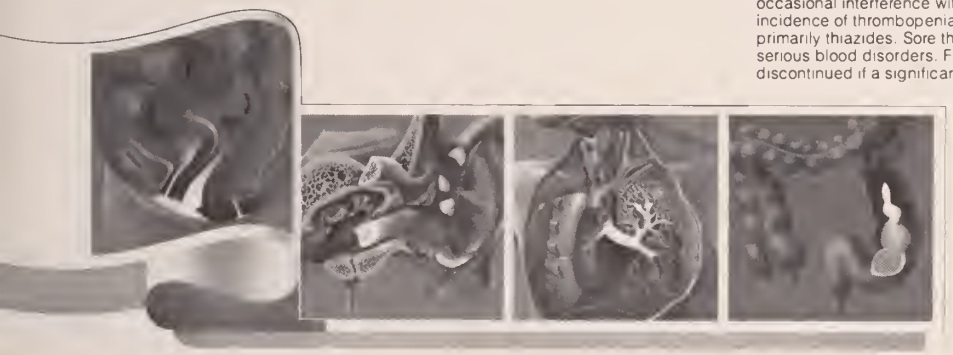
Many people are aware that the 65-plus age group is the fastest growing segment of the U.S. population, increasing twice as fast as the general population. A lesser known fact is that the number of people age 85 and over has increased by 60% since 1970. "Insurance Economics Surveys" notes that many senior citizens are becoming part of what is called the "mightiest lobby in Washington." Membership in the National Association of Retired Persons has grown to 12.5 million from 3 million in 1970. Some 4 million belong to the National Council of Senior Citizens.

During the annual scientific session of the American College of Cardiology, physicians were urged to make a major effort to persuade patients to act to reduce risk factors associated with coronary disease. A task force report dealing with the private practitioner's role in heart disease prevention acknowledged the responsibility of the individual citizen for his or her own health, but said it is the physician's responsibility to educate the public about such risk factors as smoking, hypertension, high serum cholesterol, physical inactivity and obesity.

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy



in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects. Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN.

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

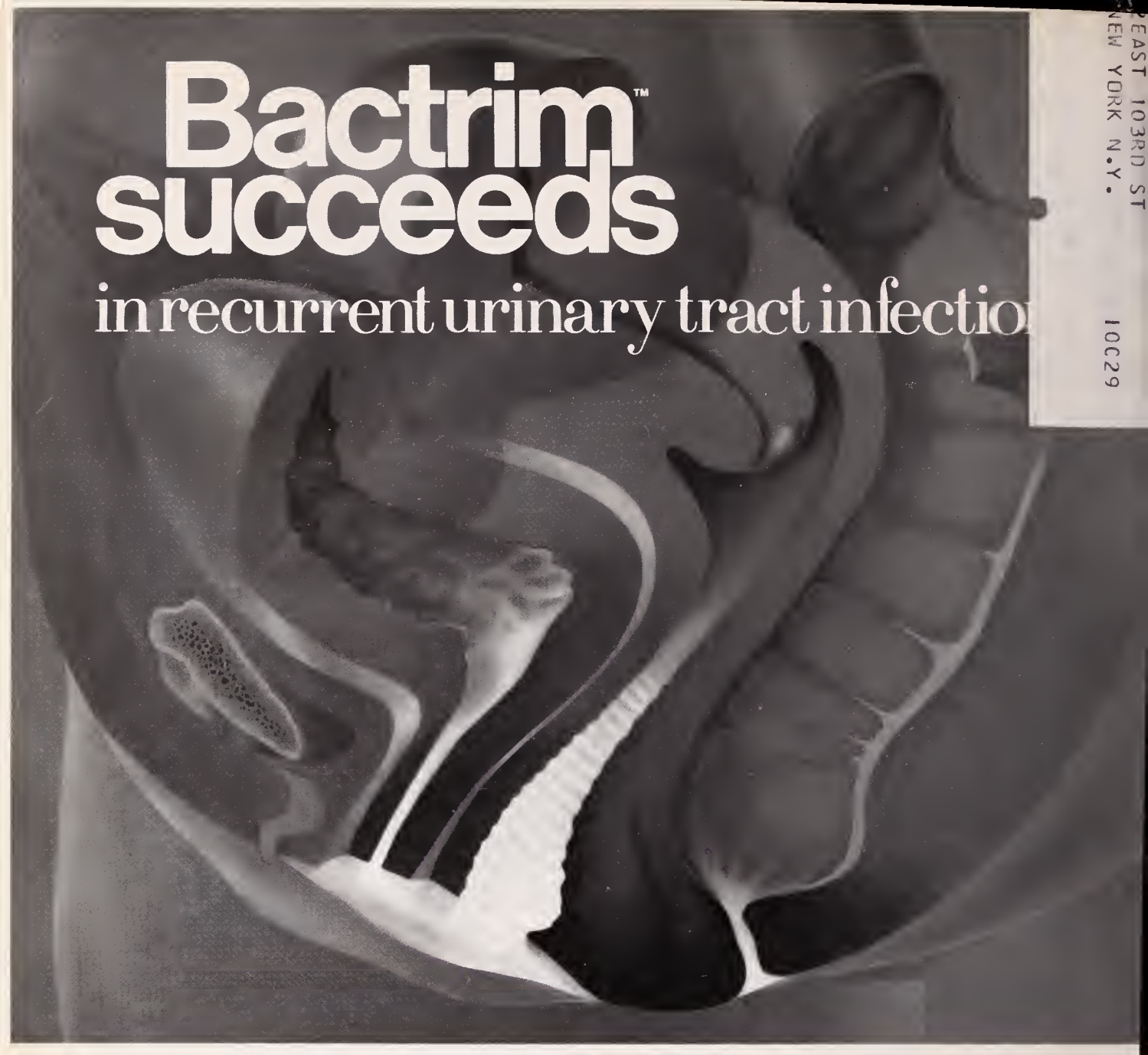
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

May 1981

JOURNAL of the MISSISSIPPI State Medical Association

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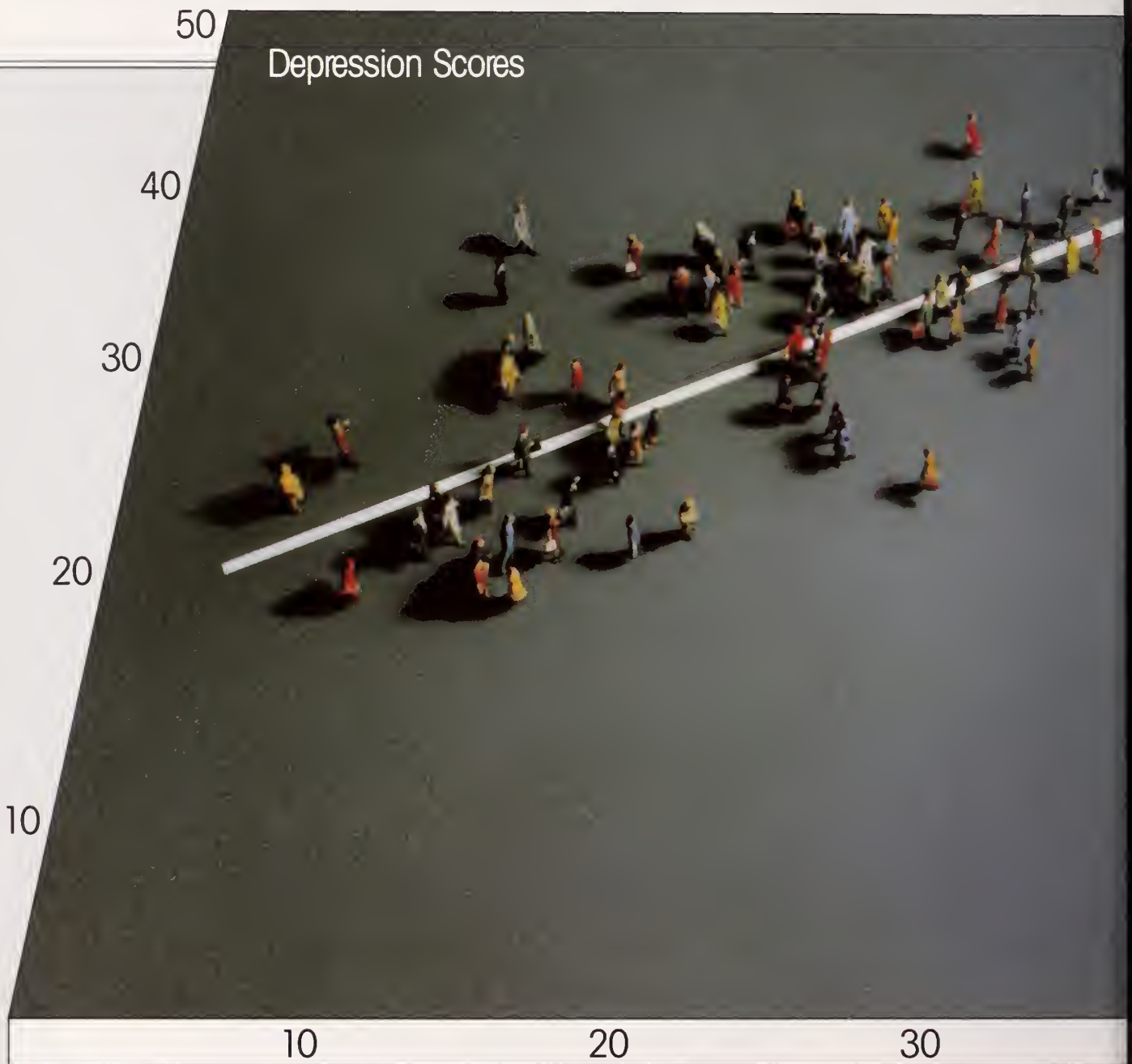
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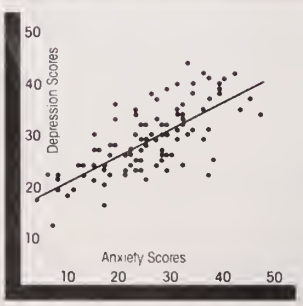
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The Effect of Budget Cuts on Health Care Programs in Mississippi — Part 1
Medicaid Looks at Reductions in Benefits, Payments, Eligibility

FOR THE 7 OF 10 NONPSYCHOTIC





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone, more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Clagharn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]



Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crafts, 1977, p. 316. **2.** Schatzberg AF, Cole JO. Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Clagharn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

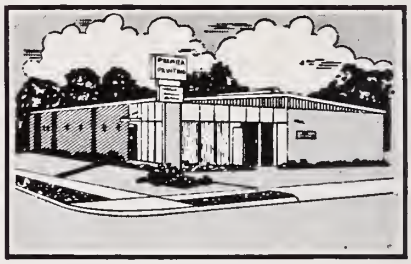
Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.
In the elderly and debilitated, limit to smallest effective dosage to preclude toxic, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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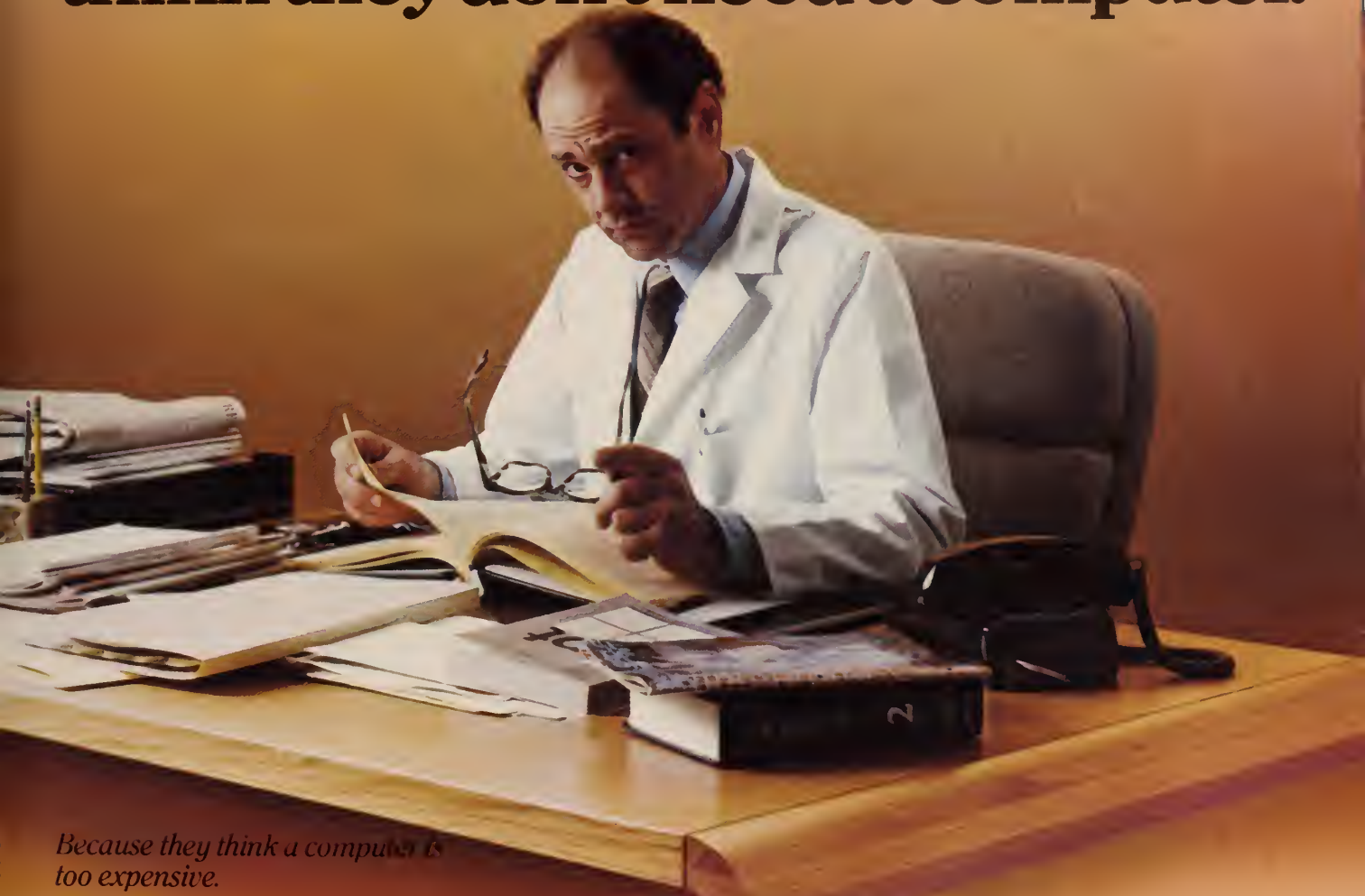
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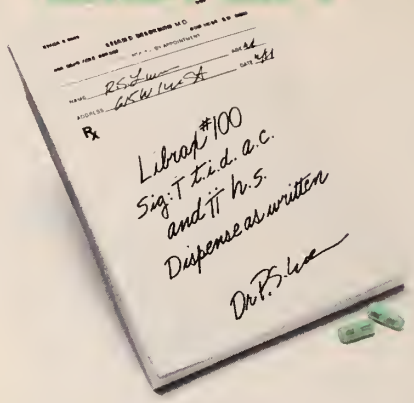
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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

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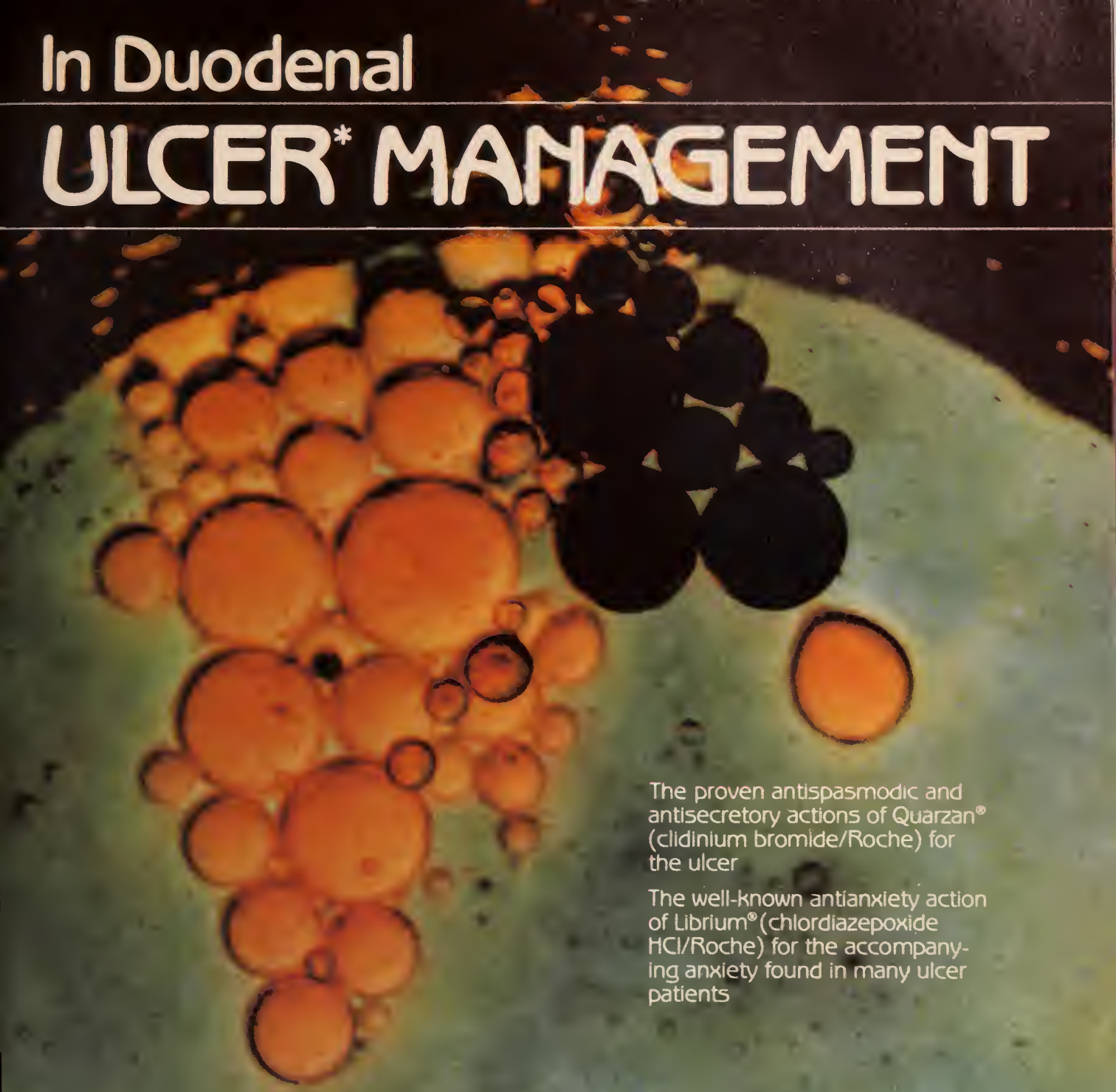
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence*. Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*. Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*. Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of January, 1980

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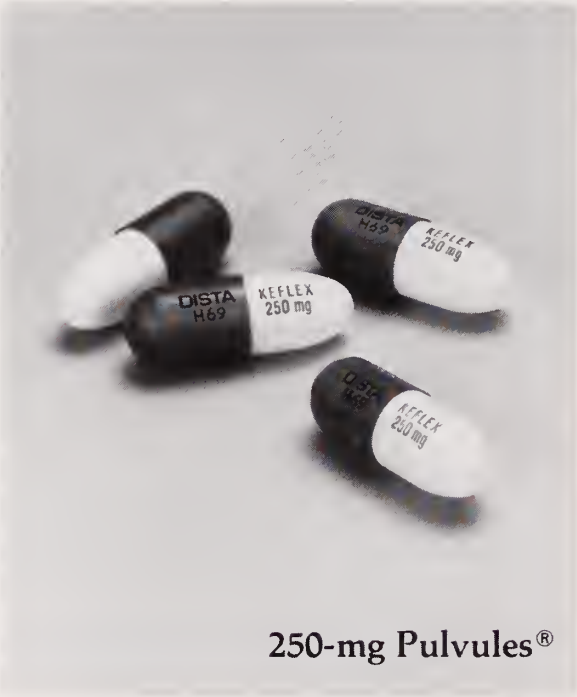
References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga, M.T. et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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NEWSLETTER

May 1981

Dear Doctor:

One out of five patients in a general medical practice is in fact an alcoholic, says Dr. Mark A. Schuckit of the VA Medical Center alcoholism treatment program in San Diego. He charges that physicians are missing the mark in identifying alcoholic patients because they are trying to diagnose alcoholism on the basis of how much somebody drinks or on the severity of their withdrawal symptoms. He says most alcoholics in the VA population do not suffer serious withdrawal.

> He says most doctors have a misconception of the "typical alcoholic." Alcoholism is so prevalent, he says, that he considers it a possibility in almost every patient presenting with certain kinds of symptoms, including hypertension, high blood fats, insomnia, impotence, depression, repeated infections, high uric acid, cardiac arrhythmias.

Many of the proposed national health planning goals are beyond the scope of the health care system and many are already being pursued through other federal programs, the AMA told the Health and Human Services Department. The AMA said it maintains a strong interest in constructively participating in the promulgation of planning policies, even though it favors the repeal of the Health Planning Act.

Practice expenses and gross income more than doubled during the 1970s, with the proportion of practice expenses to gross income rising. These and other changes in average income, expenses, fees, visits, hours worked, and waiting time for the typical office-based U.S. physician were documented by AMA staff and are described in the article, "Physicians' Practice Experience During the Decade of the 1970s."

Voluntary efforts by physicians to restrain the increase in fees has been very successful, reports the Voluntary Effort to Contain Health Care Costs. During almost every month of a 2½ year period, the physician services index of the CPI increased less rapidly than the all-items index. The complex medical care price index rose 10% in 1980, compared with 12.4% for the all-items index.

The American Cancer Society will conduct a nationwide study of one million Americans to determine how an individual's lifestyle affects chances of developing cancer. The new study will focus on such issues as whether low-tar, low-nicotine cigarets are truly less harmful, whether oral contraceptives have either harmful or protective effects, and the effects of air pollution and low levels of radiation.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

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Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.
Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.
PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.
Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.
Dosage and Administration The VERMOX tablet may be chewed, swallowed or crushed and mixed with food. For control of pinworm (enterobiasis) a single tablet is administered orally, one time. If patient is not cured three weeks after treatment, a second course of treatment is advised.

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Fort Rucker, Dothan, AL
Fort Jackson, Columbia, SC
Fort Bragg, Fayetteville, NC

Vacancies may vary as physicians arrive and depart but will exist in nearly every speciality at one medical facility or another. To obtain more information and vacancies by speciality please contact the Army Medical Department Personnel Counselor listed below. Be our guest at one of the above medical facilities or any other Army Medical facility.

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DATELINE

Art of Healing Exhibit Continues

Jackson, MS - "The Art of Healing: Medicine and Science in American Art" continues through June 7 at the Mississippi Museum of Art in Jackson. The exhibit brings together three centuries of American art dealing with medicine. Approximately 50 works make up the exhibit, including paintings by Homer Winslow, George Catlin, Norman Rockwell and John Sloan. Local physicians and medical related organizations provided funds to bring the exhibit to Jackson.

Nursing School Will Close

Jackson, MS - St. Dominic Hospital School of Nursing, which has graduated over 390 nurses since its first student enrolled in 1949, will begin phasing out the nursing program. Escalation of the cost of operating the program and a consistently small enrollment made the decision necessary, according to Sister Josephine Terese, administrator and chairman of the Governing Board of St. Dominic-Jackson Memorial Hospital. The present freshman class will graduate in 1983.

Death Claims Dr. Levine

Jackson, MS - Dr. Julius Levine of Hayward, CA, University of Mississippi alumnus and UMC benefactor, died April 11. Dr. Levine was president-elect of the Medical Alumni Chapter of the University of Mississippi Alumni Association at the time of his death. In 1979 he gave the University title to $13 million in silver mining claims. His daughter Susan Levine Bessar plans to begin her first year of family medicine residency at UMC in July.

Arizona Proposes Indigent Care Plan

Chicago, IL - "American Medical News" reports that Arizona is seeking approval of a plan to provide federally funded health care to indigents. Arizona is the only state that has never implemented a Medicaid program. The proposed prepaid health plan differs from Medicaid because it would be administered in the private sector. Some 250,000 citizens would be eligible for coverage. Approval of the plan requires numerous waivers of federal guidelines.

HMOs Fail to Cut Health Costs

Menlo Park, IL - Adding an HMO option to workers' benefit programs has not cut health care costs for many companies according to a Louis Harris and Associates survey for the Henry J. Kaiser Family Foundation. While most of the executives surveyed saw little effect on costs, they reported a perceived employee dissatisfaction with HMOs regarding quality of care. One major disadvantage cited was "no choice of doctor."

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo–

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

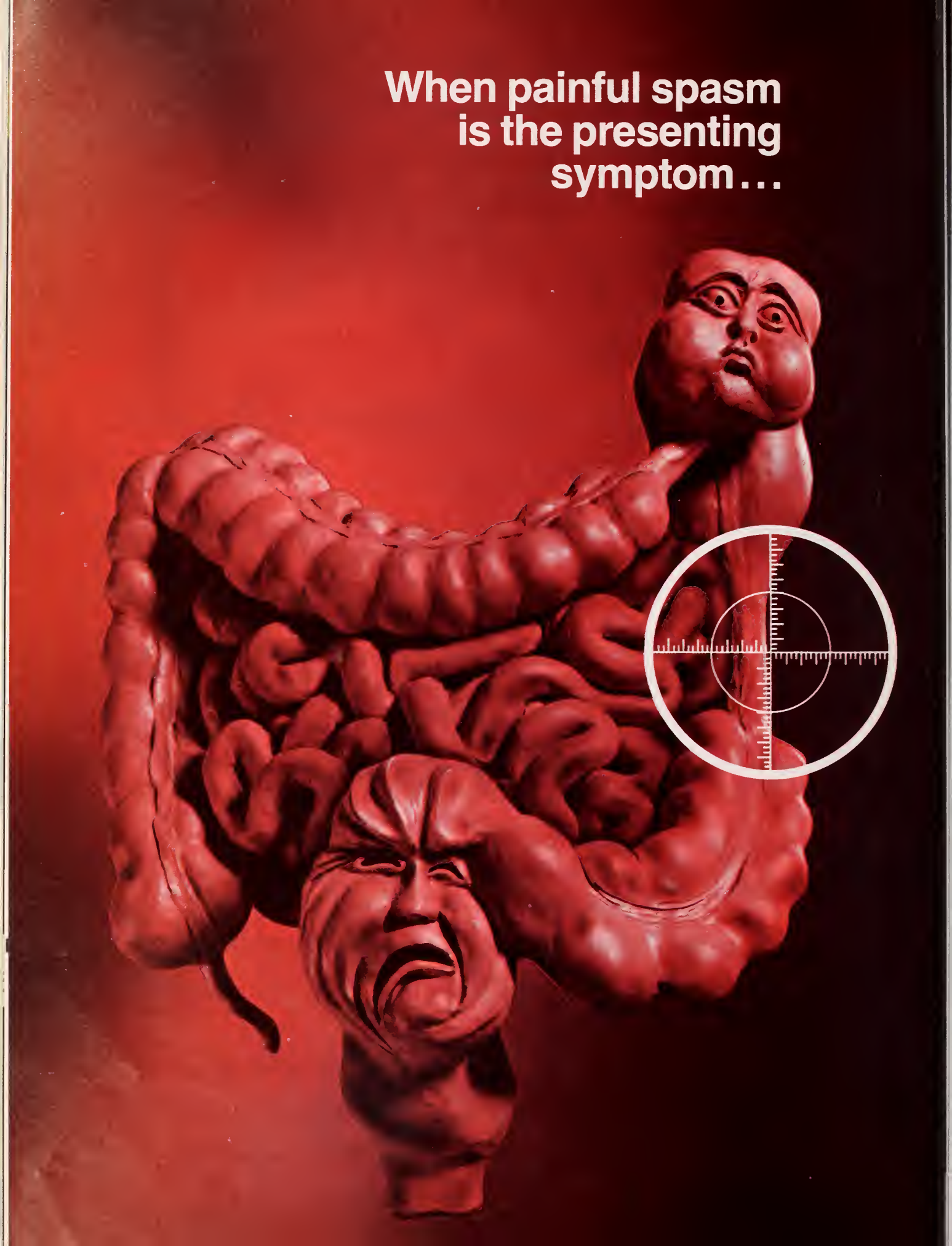
N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:
Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

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When painful spasm is the presenting symptom...



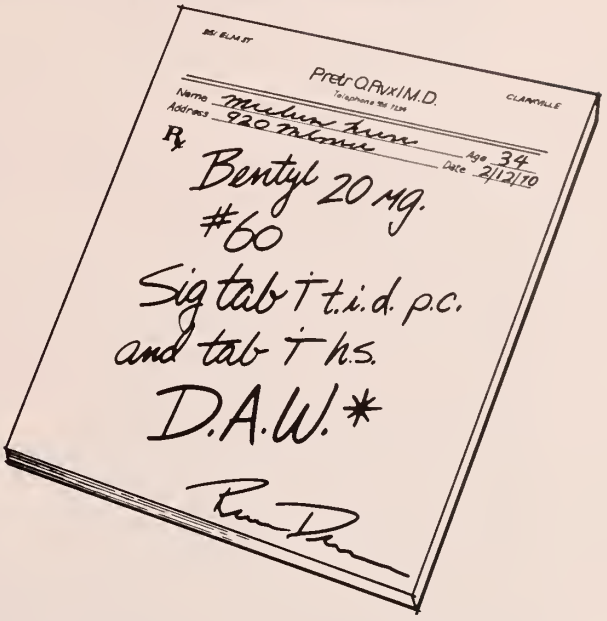
...in the functional bowel/irritable bowel syndrome†

be sure to specify

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



*D.A.W.-Dispense as written

because:

Bentyl passes these tests for product integrity.

- The Bentyl molecule is a product of original Merrell research.
- At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- Bentyl bioavailability of tablets, capsules, syrup and injectable.
- The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- Pharmacologic effect in the distal colon compared to placebo†† shows how Bentyl affects abnormal motor activity in the irritable colon patient.†

† This drug has been classified "probably" effective for this indication.

Merrell

†† In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL OISORDERS ARE OFTEN RELIEVEO BY VARYING COMBINATIONS OF SEOATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

AOVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

OOSAGE AND AOMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Oilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Oecatur, Illinois 62525 for
MERRELL-NATIDNAL LABORATORIES
Division of Richardson-Merrell Inc.
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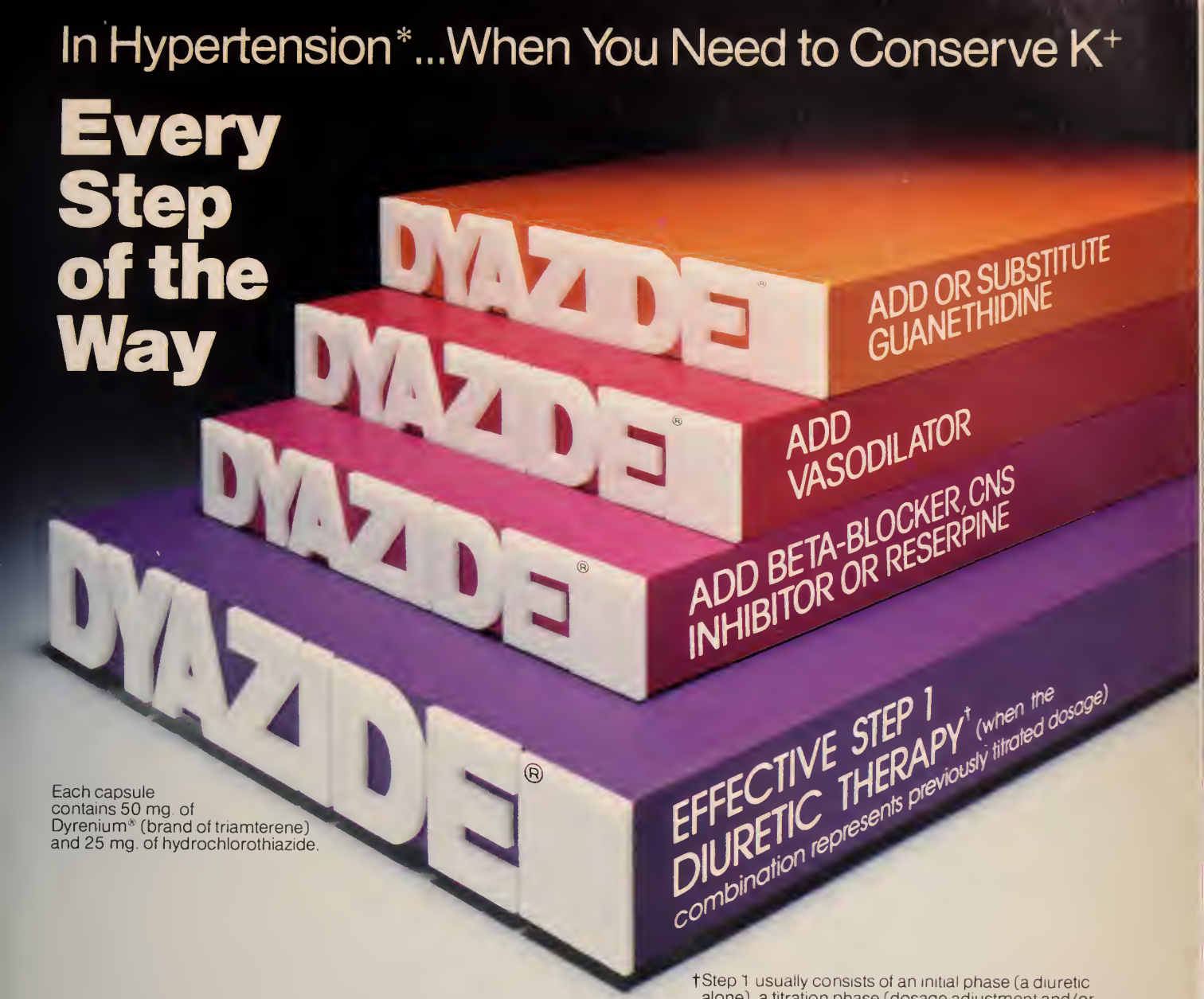
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In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded), in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. Dyazide® interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and Dyazide should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Dyazide should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of Dyazide although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules. Single Unit Packages (unit-dose) of 100 (intended for institutional use only) in Patient-Pak™ unit-of-use bottles of 100.

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SK&F CO.
a SmithKline company
Carolina, P.R. 00630

Motrin® vs aspirin w/codeine...
(ibuprofen)

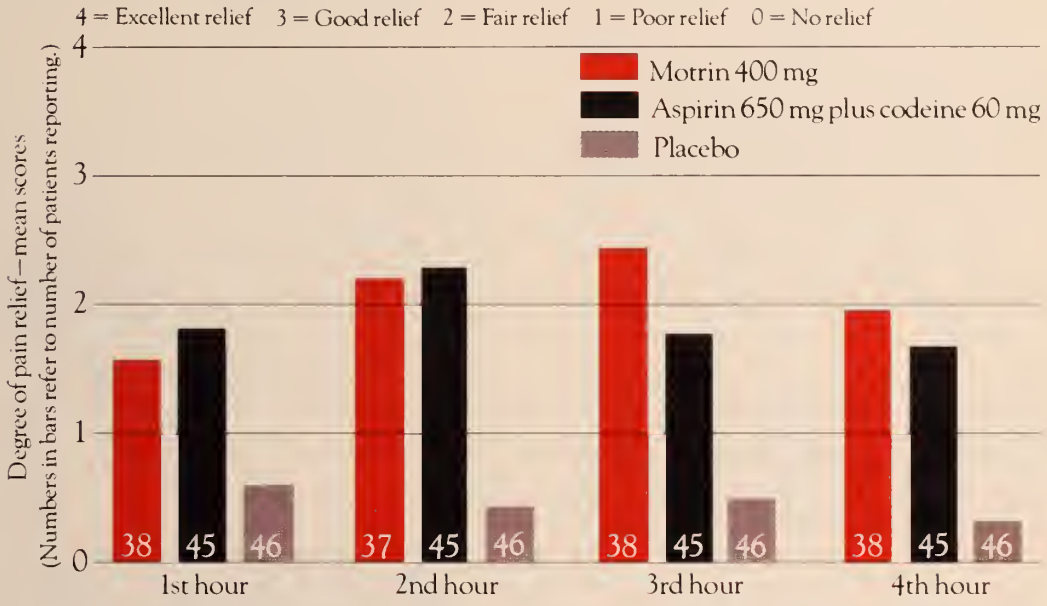


©1981 The Upjohn Company

compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

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J-8260-4

MARCH 1981

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
May 1981, Vol. XXII, No. 5

ORIGINAL PAPERS

Lung Cancer Update and Clinical Review

BENTON M. HILBUN, M.D
Tupelo, Mississippi

CARCINOMA OF THE BRONCHUS has become the most frequent form of cancer in men. This in part explains the vast amount of research, publication, and public interest in this disease process. We have undertaken the task of reviewing in a general sense what we know of lung cancer and presenting 125 consecutive cases over a five year span of a private surgical practice. We would hope that this information might prove useful to the practitioner as a brief review and a report of cases as to the management and outcome.

One of the earlier reports of lung cancer was in 1912 by Adler, who presented 374 cases. Since that early series there has been a progressive and rapid increase in reports and incidence of lung cancer. In 1968 approximately 60,000 Americans developed lung cancer. It has become apparent that lung cancer may be related to many factors, primarily environmental products of civilization. Many causative factors have been put forth and subsequently discarded. Tuberculosis, influenza, bronchiectasis, anthracosis, and congenital cystic disease of the lung have been found to have only a causal relationship to cancer.

There is, however, adequate experimental and epidemiological evidence to incriminate various industry-related chemicals. Radioactive metals, arsenic, asbestos, and of course smoking, have been shown to produce lung cancer. A person who smokes two packs of cigarets per day has a one chance in ten of developing lung cancer. Smokers have a sixty times greater incidence of lung cancer than non-smokers. It is obvious that although there are numerous causes of lung cancer, the greatest risk appears to be related to tobacco inhaling and air pollution. In 1980 there were more than 100,000 deaths due to lung cancer in the United States.

From the Department of Surgery, North Mississippi Medical Center, Tupelo, MS.

Carcinoma of the bronchus has become the most frequent form of cancer in men, and may soon be the most frequent form of cancer in women. The author presents a review of the classifications, stages, symptoms, diagnosis, and treatment. One hundred twenty-five consecutive cases of lung carcinoma are reviewed with special emphasis on mode of treatment, type of tumor, and survival.

In general there are three distinct groups of carcinoma: squamous cell, large cell and small cell. This is the Kregburg classification. The World Health Organization has further modified this to the listing below:

I) Squamous Cell Carcinoma
   a) well-differentiated (keratinized)
   b) poorly-differentiated (non-keratinized)
II) Adenocarcinoma
   a) clear cell
   b) giant cell
   c) bronchiolar (alveolar cell)
III) Adenosquamous (mixed)
IV) Oat Cell (small cell)
V) Undifferentiated Carcinoma
VI) Mucous Gland Carcinoma

Unfortunately, lung cancer can be very insidious, and symptoms may appear late in the clinical course. The location and rate of growth seem to be the principle factors. Cough and hemoptysis are frequent symptoms. Wheezing, pneumonia, pain, dyspnea, and weight loss are often seen. Dysphagia, anorexia, hoarseness, Horner's syndrome and cervical plexus pain may occur. Osteoarthropathy, hypercalcemia symptomatology and various neuropathies may also be found.

There is a well regimented program for the diagnosis of lung cancer. In general, one proceeds from the simple and non-invasive procedures to the more sophisticated methods. Chest x-ray evaluation is the first aid. Sputum cytology, endoscopic evaluation with cytology and/or biopsy, needle aspiration biopsy, node biopsy, mediastinoscopy, and finally, thoracotomy may be utilized.

The treatment of lung cancer is resection when possible. The one exception to this may be the presence of oat cell carcinoma, in which case chemotherapy may be the first approach to therapy. We have seen very little benefit from chemotherapy in all other types of lung cancer. Radiation probably offers the best palliative treatment for squamous cell carcinoma when resection is not possible.

Staging

A useful staging of the carcinoma allows for predicting prognosis and influences treatment plans.

Stage I
- No distant metastasis
- Tumor less than 3 cm in diameter, T-1
- Peribronchial nodes may or may not be positive, N-1

Stage II
- No distant metastasis
- Positive nodes at lobular level, N-1
- Tumor greater than 3 cm in diameter, T-2

Stage III
- Distant metastasis
- Mediastinum, pericardium, liver, contralateral lung, bone, N-2

Survival Rate

Unfortunately the overall cure rate of lung cancer is less than 10 percent. There is only a 25% resectability rate at the time diagnosis is made. The five year survival for lung cancer as related to the stage is shown in Figure 1.

SURVIVAL RATE OF STAGES

Pathological Stage	*Percent 5 Year Survival*
I	40-50%
II	25-30%
III	8-15%

FIGURE 1

Preoperative Evaluation

In anticipation of a resection, one must have some criteria to aid in deciding who should be subjected to a thoracotomy. Other than the usual parameters such as chemistry profile, blood counts, etc., we have used the following four areas to aid in pre-operative evaluation:

1) Blood gases — a PCO_2 of greater than 45 mm may indicate poor risk. A PO_2 of less than 60 mm and no improvement with exercise is also a poor prognostic sign.
2) Pulmonary function screen — a MBC of less than 50% of predicted and a FEV_1 of less than 60% of the vital capacity indicates significant pulmonary dysfunction.
3) Cardiac status — cardiac history and screening with cardiogram.
4) Clinical assessment — a brief but perceptual evaluation of the patient's tolerance to stress and previous activity can give much insight to the proposed surgery.

We have usually empirically given digitalis to patients undergoing a pneumonectomy regardless of other indications. We feel we have often averted heart failure and arrhythmia in this manner.

After completing the pre-operative evaluation, those cases selected for planned resection are operated upon. We utilize preoperative visits with inhalation therapists and the nursing staff from the surgical intensive care unit. Pre-operative antibiotics (usually a cephalosporin) are used, given with the preoperative medication and continued for 48 hours postoperatively. Surgery is performed utilizing a posterolateral thoracotomy incision. A rib is rarely taken. The procedure performed is dictated by operative findings. A lobectomy is the procedure of choice when this allows for resection of all the cancer. Sampling of mediastinal nodes is often done. We use the stapling device often on lung parenchyma and bronchi. Chest drainage is usually accom-

plished with two #28 Argyl catheters using non-breakable bottles of plastic. This method has proved reliable and is far less expensive than some of the newer devices. The patients are kept in the intensive care unit for a minimum of 48 hours following surgery. The usual period of hospitalization is eight to ten days, including the preoperative evaluation period.

PATHOLOGICAL CLASSIFICATION OF 125 CASES
LUNG CARCINOMA

Cell Type	*Number*	*Percent*
Squamous Cell	62	50
Adenocarcinoma	15	12
Large Cell	14	11
Small Cell (not oat cell)	8	6
Oat Cell	16	12
Undifferentiated	8	6
Alveolar Cell	2	1

FIGURE 2

DIAGNOSTIC PROCEDURES PERFORMED IN 125 CASES
LUNG CARCINOMA

Procedure	*Number*	*Percent of Cases*
Bronchoscopy	112	90
Node Biopsy	21	16
Mediastinoscopy	13	10
Rib Biopsy	2	1
Thoracotomy	60	48

FIGURE 3

Clinical Review

One hundred-twenty-five consecutive cases of lung cancer from 1974 to 1980 were reviewed. These patients were admitted to the North Mississippi Medical Center on the private service of the author. The average age was 62 years with ages ranging from 36 years to 87 years. One hundred (80%) were male and 25 (20%) were female. Racial fractionation yields 110 caucasian (85%) and 15 black (15%). There were 95 known smokers (76%), 5 non-smokers (4%) and 25 (20%) whose records did not reflect.

Pathological classification of the 125 cases is seen in Figure 2. The pathology department has made a distinction between small cell (non-oat cell variety) and oat cell carcinoma.

Procedures performed on the group for diagnosis as well as definite resections were tabulated (see Figure 3).

Of the 60 thoracotomies performed, we found that resection for cure was possible in 42 of the cases, 32% of the total 125 cases. In the 42 resections performed, lobectomy was carried out in 30 instances, bilobectomy in 2 and pneumonectomy in 10.

The most frequent complaints of the patients were cough, hemoptysis, chest pain, and wheezing. Thirty-seven of the patients with lung cancer had no symptoms.

When resection was not possible, other modalities were selected. Cobalt was used in 62 cases and chemotherapy in 26. Reasons for not performing resection are illustrated in Figure 4.

Of the 125 cases, 27 patients (21%) are living and free of known disease. Ninety-eight patients have expired (79%). The highest mortality occurred during the first 12 months (see Figure 5).

In the analysis of the 42 cases that were resected for cure, we find that with a follow-up time ranging from 2 to 7 years, 27 patients are living with no known disease (64%). There have been 15 deaths (35%), two of which were due to non-cancer causes.

FACTORS PREVENTING RESECTION

	Number
Endoscopic Evidence of Non-Resectability	12
Distant Metastasis	17
Prohibitive Operative Risk	7
Pleural Effusion (malignant)	1

FIGURE 4

MORTALITY CHART OF 98 PATIENTS EXPIRED

Time of Death	*Number of Deaths*	*Percent*
0-12 Months	61	62
12-24 Months	12	12
24-36 Months	5	4
36-48 Months	4	3.5

FIGURE 5

This indicates that we can expect to offer surgical resection for cure to approximately 30% of patients with lung cancer. In the group resected we can reasonably expect a 50% to 60% five-year cure rate. In order to push more patients into the resectable group, we must make an earlier diagnosis and get these cases to resection prior to escape of cancer cells into the lymphatics, blood, or contiguous structures. In spite of the recent proclamation of the American Cancer Society, it seems only logical that persons in high risk groups, such as smokers or those exposed to carcinogens, should have a systematic screen with chest x-rays and/or sputum cytology. It is apparent that our only hope for decreasing the mortality from lung cancer lies in finding more lesions that are amenable to surgical resection. ★★★

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Bibliography

1. Adler, Isaac A.: Primary malignant growths of the lung. Cancer 30:295-300, Oct. 1980.
2. Coy, Peter and Kennelly, G. M.: The role of curative radiotherapy in the treatment of lung cancer. Cancer Feb. 15, 1980.
3. Petrovich, Z., Ohanian, M. and Cox, J.: Clinical research on the treatment of locally advanced lung cancer. Cancer 42:1129-1134, 1978.
4. Sierocki, J. S., et al: Small cell carcinoma of the lung. Cancer 45:417-422, 1980.





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Medical Management of the Menopause

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DURING THE PAST 20 years physicians widely prescribed estrogens to women entering the menopausal years to prevent the immediate signs of estrogen deficiency and to retard other disorders of aging. "Feminine forever," a slogan adopted by physicians and women, became the rationale for therapy.[1] This therapeutic philosophy underwent a sudden reexamination five years ago following publication of a series of papers linking exogenous estrogens to the development of endometrial carcinoma.[2-5] Since those initial reports, investigators have waged statistical warfare, making claims and counterclaims about estrogenic effects on the endometrium.[6, 7] Recently, retrospective data from a case-control study of menopausal estrogen therapy suggested a causal relationship between estrogen replacement therapy and breast cancer.[8]

As the data mount, the weight of evidence strongly suggests a causal relationship between exogenous estrogen and neoplasia in estrogen dependent tissues. Because of the widespread publicity given to this relationship, physicians are reticent to prescribe estrogen; women are reluctant to take estrogen. Yet, it is our view that there is sufficient understanding of the physiology of the menopause, of the mechanisms of postmenopausal estrogen production, and of the pathophysiology of estrogen deprivation to make some rational decisions about estrogen replacement therapy.

Physiology of the Menopause

At birth a girl is endowed with approximately two million primordial ovarial follicles. She draws upon this endowment during her reproductive years and by the time she reaches menopause, approximately 5,000 follicles remain. The residual follicles require an increasing concentration of follicle stimulating hormone (FHS) to induce ovulation.

Endocrine changes in the pituitary-ovarian axis begin nearly a decade before a woman's last menstrual period. The first perceptible changes in pituitary-ovarian function are variations in the menstrual cycle length and a gradual increase in basal plasma FSH concentration.[9, 10] As menopause nears, plasma FSH continues to increase until it exceeds the plasma concentration of luteinizing hormone (LH). During the prime reproductive years, the basal plasma concentration of LH is 2.5 times greater than FSH. As residual ovarian follicles become refractory to gonadotropin stimulation, estradiol-17β (E_2) production by the theca cells decreases, thus decreasing the negative feedback upon the hypothalamic-pituitary secretory mechanism. FSH concentration exceeds LH concentration.

The physiologic changes that occur in the pituitary-ovarian axis as menopause approaches require nearly ten years to become manifest. Yet, following surgical castration of reproductive-age women, these changes are immediate.[11]

Immediate symptoms of estrogen deprivation in women undergoing natural menopause and surgical menopause are hot flashes, urogenital atrophy, and mood changes. These symptoms cause women to seek medical attention.

Hot Flashes. Hot flashes (vasomotor instability) heralds menopause as the first recognizable symptom and occur to some extent in over 75% of menpausal women. Lauritzen[12] noted that surgically castrated women experienced hot flashes 4-6 days following oophorectomy.

Little is known of the pathophysiology of the hot flash, but it is clear that hot flashes follow estrogen withdrawal. Women with primary ovarian failure do not experience hot flashes (regardless of age) until they have been given exogenous estogens and are

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withdrawn from estrogens. Men, undergoing estrogen therapy for prostatic carcinoma, experience hot flashes following estrogen withdrawal.

Meldrum et al[13] documented a rapid rise in skin temperature, an increase in pulse rate, and a fall in core temperature concomitant with the hot flash episode. Casper et al[14] demonstrated that each hot flash episode is followed immediately by a pulsatile release of pituitary LH. The triggering event for the hot flash is unknown.

Low dose estrogen replacement therapy is effective in bringing prompt relief from annoying hot flashes. Medroxyprogesterone acetate, 20 mg per day, is effective therapy for hot flashes in women who cannot take exogenous estrogen.[15, 16] Clonidine, an α-adrenergic agonist administered 0.05 mg twice daily, reduced the frequency and severity of hot flashes by 88% in a study of symptomatic, postmenopausal women.[17]

Urogenital Atrophy. The vaginal epithelium, endocervical glands, endometrium, and myometrium require estrogen for normal function. Estrogen deprivation results in atrophy of these tissues. The vaginal epithelium becomes thin and loses its rugated surface; the endocervical glands cease secreting mucus; the endometrium fails to slough at periodic intervals; the myometrium undergoes involution. The bladder and uretheral epithelium may undergo partial atrophy along with the reproductive tissues.

Menopausal women perceive these changes as dyspareunia (due to thinning of the vagina), dryness of the vagina (due to diminished vaginal and cervical mucus secretion), and urinary frequency and urgency (due to loss of bladder support). Estrogen is perhaps the only effective agent for atrophic vaginitis and urethritis. Low dose estrogen treatment will prevent or reverse genital atrophy.[18]

Mood Changes. Menopausal women complain of mood changes and emotional instability in their early menopausal years. Depression, despondency, lack of self-interest, lack of sexual interest, insomnia, irritability, and impairment of recent memory are frustrating changes for women who formerly led active, adjusted lives. For lack of a physiologic explanation, these complaints have been attributed to an "empty nest syndrome" or a sense of diminished worth due to reproductive failure.

Recent advances in the knowledge of estrogen metabolism and in neuroendocrinology may offer some basis for understanding the mood disturbances that accompany menopause. When radiolabeled estradiol is infused into normal volunteers, part is metabolized by 16α-hydroxylation resulting in the formation of estriol, and part is metabolized by 2-hydroxylation resulting in the formation of 2-hydroxyestradiol.[19] The latter compound is named a catechol estrogen because of the identical structure of the "A-ring" of the steroid nucleus and the catechol ring of the catecholamine neurotransmitters. Catechol estrogens are formed in high concentrations in the hypothalamus, and moreover, these estrogen metabolites compete with the neurotransmitters for the metabolizing enzyme, catechol-0-methyltransferase.[20] Thus, an important chemical link exists between estrogens and catecholamine neurotransmitters that may play an important role in central nervous system function.

The response to estrogen treatment in alleviating these emotional complaints is unpredictable and difficult to evaluate objectively. Yet, women receiving estrogen replacement therapy note improvement in their psychologic well-being. Schiff et al[21] report that women receiving low dose conjugated estrogens experience improvement in sleep pattern and quality of sleep, a sense of being less aggressive, and improvement in their sense of self-worth. Despite the psychologic improvement and alleviation of dyspareunia, estrogen therapy does not increase libidinal desire.

Estrogen Production in Postmenopausal Women

In premenopausal ovulatory women, estrogen is produced in two ways: (1) estradiol 17-β is secreted by the ovarian follicles, and (2) estrone is formed in extraglandular tissue sites (adipose tissue, liver, muscle) by the aromatization of plasma androstenedione, which is of adrenal and ovarian origin. With the cessation of estradiol-17β secretion by the ovary, menopause occurs.

With menopause, neither the gland nor the ovary secretes estrogen. However, estrogen production is not static or absent in postmenopausal women as the mechanism for extraglandular estrogen production is enhanced by age[22] and is further accelerated by obesity[23] and hepatic disease.[24] Additionally, an increased rate of estrone formation is found in premenopausal and postmenopausal women with increased production of androstenedione as found in polycystic ovarian disease and ovarian neoplasia.

Estrogen production in the postmenopausal woman is characterized by extraglandular formation of estrone, rather than by secretion of estradiol-17β.[25] A comparison of extraglandular estrone pro-

duction in premenopausal women and postmenopausal women is presented in Figure 1.

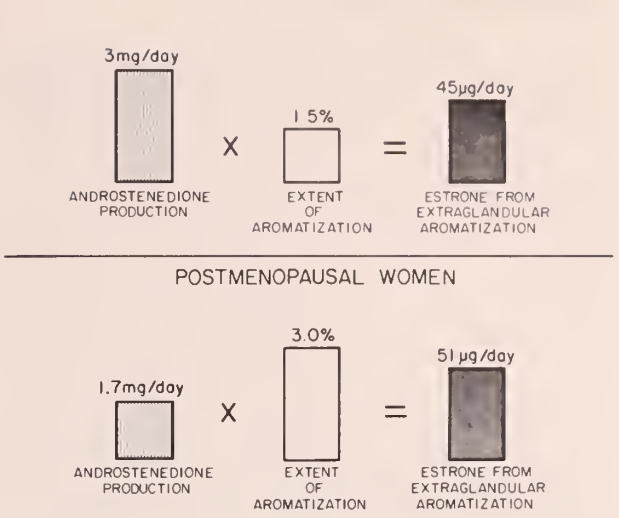


Figure 1. Net extraglandular estrone production is equal in premenopausal and postmenopausal women. Both the ovaries and adrenal glands secrete androstenedione in premenopausal women, but the extent of aromatization is only 1.5%. In postmenopausal women, androstenedione production is reduced by 50% with ovarian failure, but the extent of aromatization doubles.

Long Term Effects of Estrogen Deprivation

Osteoporosis. Beyond age 20 years, bone resorption increases modestly throughout life in normal individuals. With normal formation and increased resorption, bone density gradually decreases in the normal population. All patients with osteoporosis appear to have an increased rate of resorption regardless of the cause.

Albright and associates[26] first suggested an association between osteoporosis and the menopause. In men and women who have gonadal failure at puberty, osteoporosis is an almost universal finding by age 30 years. Estrogens do not seem to stimulate bone formation, but may inhibit bone resorption.

Meema and Meema[27] found that castrated women have significantly less bone mass than premenopausal women of the same average age. They found that untreated postmenopausal women demonstrated a significant loss in bone mass, while estrogen treated postmenopausal women showed no such loss.

Aitken et al[28] made prospective studies of bone mass in women following oophorectomy for benign conditions. Untreated women lost bone mass at an accelerated rate in the two years following oophorectomy, while those women who received estrogen replacement (mestranol) had no acceleration of bone resorption. When estrogen replacement therapy was initiated within three years of oophorectomy, bone mass increased. However, when estrogen replacement was delayed for six years beyond surgical castration, estrogen replacement had no effect on bone mass.

Daniell[29] reported an epidemiologic analysis of women that links osteoporosis with a slender body habitus (< 110% of ideal body weight) and smoking. From these data, the author suggests estrogen deficiency as a cause of osteoporosis.

On the basis of available data, the use of estrogens appears warranted in women at high risk for osteoporosis. These are slender (< 110% of ideal body weight), Caucasian women who smoke. Moreover, women with premature ovarian failure and those undergoing surgical menopause may benefit from estrogen replacement to retard bone demineralization.

Cardiovascular Disease. In younger life, myocardial infarction occurs more frequently in men than in women. In the 25-35 year age range the sex ratio (M : F) is approximately 7 : 1. By age 80 the ratio becomes equal. This disparity in the risk of cardiovascular disease is attributed to the protective effects of estrogens during the premenopausal years. Epidemiologic data to support such a relationship are lacking. Such variables as life-style, smoking, hypertension, and stress are more likely causal factors in the risk of cardiovascular disease. The administration of estrogen as prophylactic protection against cardiovascular disease is unwarranted.

Estrogen Replacement Therapy

Vasomotor instability, urogenital atrophy, and mood alterations are symptoms of estrogen deficiency. Ninety percent of women who experience these symptoms will achieve relief following administration of replacement estrogen. Yet, many women are reluctant to take estrogen because of their concern for developing endometrial neoplasia and, possibly, breast neoplasia.

We recommend estrogen replacement therapy for symptomatic perimenopausal and postmenopausal women, but withhold estrogen therapy from asymptomatic women. Asymptomatic postmenopausal women most likely have adequate (or excessive) extraglandular estrone production to sustain the

estrogen-dependent tissues and retard or prevent osteoporosis. Asymptomatic postmenopausal women tend to be obese, whereas symptomatic postmenopausal women tend to be slender.

For replacement therapy we administer conjugated equine estrogens, 0.625 mg for 25 days each month. For the last 10 days of replacement therapy (days 16-25), we add 10 mg per day of medroxyprogesterone acetate. The rationale for the addition of a progestin to the estrogen replacement regimen is to prevent the development of endometrial neoplasia. Sturdee et al[30] reported the protective effect of progestins on the endometrium in 348 postmenopausal women who received various regimens of estrogen replacement. Estrogen implants were associated with 28% incidence of endometrial neoplasia; unopposed oral estrogen was associated with a 12% incidence of endometrial endoplasia; estrogen plus extended (greater than 7 days) progestin therapy was associated with a 2% incidence of endometrial neoplasia. Gambrell et al[31] have confirmed the reduced incidence of endometrial carcinoma among post menopausal women treated with progestins.

Postmenopausal women respond in various ways to estrogens. Most have a resolution of symptoms with 0.625 mg of conjugated equine estrogens. However, some women fail to absorb the enteric-coated estrogen tablet, while others fail to remove the sulfate conjugate from the estrone sulfate molecule. These women do not respond to conjugated equine estrogens, and it is unlikely that a further increase in dosage will produce a therapeutic response.

For those women who are apparently refractory to estrogen replacement, we administer estradiol-17β, 1 mg per day for 25 days. It is rare that a woman will fail to respond to this therapy.

Occasionally, estrogen replacement is contraindicated in symptomatic postmenopausal women because of breast neoplasia, hepatic disease, and endometrial neoplasia. Oral medroxyprogesterone acetate, 20 mg per day[15], or depo-medroxyprogesterone acetate, 100 mg IM,[16] relieved hot flashes in 74%-80% of the subjects studied. Side effects from this therapy were minimal.

Conclusions

We conclude that hot flashes, urogenital atrophy, and mood changes are immediate symptoms of estrogen deficiency in perimenopausal and postmenopausal women. Osteoporosis is an associated, remote consequence of estrogen deficiency. The risk of endometrial neoplasia is increased in women exposed to excess estrogen when the estrogen is unopposed by progesterone or a synthetic progestin, but the risk of developing endometrial neoplasia is substantially reduced when a progestin is added to the estrogen replacement regimen.

We recommend estrogen replacement for symptomatic postmenopausal women. We do not recommend estrogen replacement for asymptomatic post menopausal women; these women probably have adequate endogenous estrogen production to sustain the estrogen-dependent tissues.

Failure to respond to estrogen replacement may reflect malabsorption of estrogen or a defect in the metabolism of estrogen. Frequently, women who fail to respond to conjugated equine estrogens will respond to another oral estrogen preparation. ★★★

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References

1. Wilson, R. A. and Wilson, T. A.: The fate of the nontreated postmenopausal woman: A plea for the maintenance of adequate estrogen from puberty to the grave. J. Am. Geriat. Soc. 11:347, 1963.
2. Smith, D. C., Prentice, R., Thompson, D. J. et al: Association of exogenous estrogen and endometrial carcinoma. N. Engl. J. Med. 293:1164, 1975.
3. Zeil, H. K., and Finkle, W. D.: Increased risk of endometrial carcinoma among users of conjugated estrogens. N. Engl. J. Med. 293:1167, 1975.
4. Mack, T. M., Pike, M. C., Henderson, B. E. et al: Estrogens and endometrial cancer in a retirement community. N. Engl. J. Med. 294:1267, 1976.
5. McDonald, T. W. Annegers, J. F., O'Fallon, W. M. et al: Exogenous estrogen and endometrial carcinoma: Case control and incidence study. Am. J. Obstet. Gynecol. 127:572, 1977.
6. Horwitz, R. I., and Feinstein, A. R.: Alternative analytic methods for case-control studies of estrogens and endometrial cancer. N. Engl. J. Med. 299:1089, 1978.
7. Antunes, C. M. F., Stolley, P. D. Rosenstein, N. B. et al: Endometrial cancer and estrogen use. N. Engl. J. Med. 300:9, 1979.
8. Ross, R. K., Paganini-Hill, A. Gerkins, V. R., Mack, T. M. et al: A case-control study of menopausal estrogen therapy and breast cancer. J.A.M.A. 243:1635. 1980.
9. Sherman, B. M. and Korenman, S. G.: Hormonal characteristics of the human menstrual cycle throughout reproductive life. J. Clin. Invest. 55:699, 1975.
10. Sherman, B. M., West, J. H. and Korenman, S. G.: The menopausal transition: Analysis of LH, FSH, estradiol, and progesterone concentrations during menstrual cycles of older women. J. Clin. Endocrinol. Metab. 42:629, 1976.

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Radiologic Seminar CCXIV: Contrast Reactions

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Physiological and topical sequelae to the use of parenteral iodinated contrast media are commonly referred to as "contrast reactions." The author suggests a means of classifying such sequelae and proposes an alternate term to describe these phenomena.

EVER SINCE THE USE of parenteral iodinated contrast media was begun, certain physiologic and topical sequelae to its use have been observed. It has been common in the radiologic literature and in medical vocabulary to refer to the occurrence of these sequelae as "contrast reactions." It is obvious that those events included in this very broad categorization represent a broad spectrum of phenomena. It is the purpose of this brief paper to suggest a new term to replace "contrast reaction," to briefly summarize observations at the North Mississippi Medical Center with respect to contrast sequelae, to suggest a simplified means of classifying contrast sequelae, and to suggest a generally more rigorous approach to our thinking about and our treatment of these phenomena.

It would appear wise to object to the use of the term "contrast reaction" on two grounds. The term is imprecise and limited. Furthermore, the term has come to connote an allergic reaction only. This is clearly a much too limited view of contrast sequelae. It is my suggestion that we replace "contrast reactions" with the term "contrast interaction." It is clear that the events which we are attempting to describe and categorize represent a very broad array and include: the physiologic and biochemical interactions between iodinated contrast media and body fluids; the properties of iodinated contrast media to stimulate the immune and allergic systems of the body; the psychological reaction of the human being, to both the administration of contrast media and to the environment of its administration; the direct predictable effects of contrast media on tissues; and the very important property of contrast media to stimulate the hypothalamus and vagal-autonomic systems.[1, 2, 4]

Fifty-six consecutive cases of contrast interactions occurring at the North Mississippi Medical Center which were treated by drug administration were recently reviewed. The vast majority of these (95%) involved the occurrence of urticarial wheals and itching. In two cases the urticarial reaction occurred prior to the administration of any contrast. The majority of these urticarial interactions were treated with intramuscular Benadryl, with resultant rapid clearing. Two cases were treated with intramuscular or intravenous Valium and demonstrated equally rapid clearing of the urticaria. There were two cases of rather prominent vaso-vagal responses to contrast material. These cases constitute a statistically small, however, physiologically very important group of contrast interactions. The symptom complex was uniformly monotonous and consisted of a subjective sense of warmth, diaphoresis, bradycardia, hypotension, and syncope. The patients responded quickly and totally to the administration of intravenous atropine. It is very important to recognize this group of patients and to treat them as a vaso-vagal phenomenon and not as an anaphylactic event. No true anaphylactic interactions occurred in the series reviewed. One such event has occurred in the Radiology Department of North Mississippi Medical Center in the last eight years. That patient required intubation, administration of epinephrine and rather lengthy supportive care. Contrast agents involved in the above incidents were: Conray 400 — 23, Hypaque — 26, Cholografin — 2, Conray 60 — 5.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, North Mississippi Medical Center, Tupelo, MS

Classification of Reactions

A somewhat simplified, yet systematic way of classifying contrast interactions is needed. The vast array of possible contrast interactions defies any truly comprehensive way of classifying these events. It is useful, however, to view the overall matter in some systematic way. It is my suggestion that the following classification proves to be pragmatic.

I. Direct effects of contrast media
   A. Minor effects (flushing, arm pain, nausea, and vomiting). These events alone are not significant and are not predictive of any more serious interactions. These represent either direct contrast-tissue reactions, central stimulation, or vasomotor response.
   B. Serious effects — tissue or organ toxicity (for example neurotoxicity, renal toxicity and spleen toxicity as a result of either prolonged exposure or high concentration). Neural tissue is the prototype of this direct effect and exhibits cellular death as a result of exposure to high concentrations of iodinated contrast. Kidney and spleen are also good models.[2]

II. Vaso-vagal response

This is an extremely important and perhaps most important category clinically. Symptom complex briefly described above is typical. The treatment is effective, recovery is complete, and the need to distinguish this from anaphylactic phenomena is critical.

III. Topical or atopical contrast interaction
   A. Hives
   B. Itching
   C. Anxiety

These interactions are those which, in our institution, have commonly been treated with Benadryl. It is likely that these are not true allergic manifestations in the majority of cases. As indicated above this same complex may occur without the administration of contrast. It is also interesting to note that in a few cases Valium has proved to be effective treatment. Many of these interactions need no treatment, and while many of them are reproducible in an individual patient they are not necessarily predictive of any more serious or consequential contrast interaction.

IV. Allergic interactions
   A. Mild — bronchospasm
   B. Serious — anaphylactoid reactions

These interactions require treatment and require caution before subsequent administration of contrast. However, these events are not absolute contraindications to future contrast administration.[4, 7]

V. Other systemic manifestations
   A. Shaking chills
   B. Cardiac arrhythmia
   C. Pulmonary edema
   D. Consumption coagulopathy

These events appear to be mediated by the hypothalamus.[3]

Clinical Recommendations

Based on our experience and on literature review some clinical recommendations regarding contrast interactions are offered. Any patient having an apparent systemic interaction to contrast in a radiology department should be considered first to be undergoing a vaso-vagal response. Pulse rate should be ascertained and if bradycardia is present and if the symptom complex described in this paper obtains, then atropine should be quickly administered and the patient should *not* be treated as if anaphylaxis is occurring. Those patients experiencing urticaria, itching, and anxiety should be approached with calmness and with reassurance. It is our recommendation that only those who are particularly symptomatic should be treated with any medication, and that the objective of drug administration should be to alleviate the distressing symptoms which are actually present. For this reason we suggest that the use of the Benadryl is probably too ubiquitous and that it is not necessarily the drug of choice in this situation. It is also our suggestion that these particular patients not be categorically prohibited from future contrast administration since the occurrence of these topical responses alone has no predictive value for more consequential interactions.[7] The minor direct effects of contrast (flushing, nausea, and extreme discomfort) occur in the vast majority of patients receiving contrast and are present in varying degrees of intensity. These phenomena are totally inconsequential, have no predictive value, and constitute the prime example for not considering all contrast interactions as allergic reactions. The serious direct effects of contrast usually are related to arteriography and represent a technical problem. Those patients who experience "true" allergic manifestations usually require treatment, the intensity of which must be gauged by the severity of the interaction. These events, while certainly requiring extreme future caution are not absolute contraindica-

tions to future administration of contrast. Valium has promise in the prevention of those systemic manifestations mediated by the hypothalamus.[1]

Finally, the term contrast interaction enbraces a wide spectrum of events which can be observed following the parenteral administration of iodinated contrast material. It is our suggestion that the appropriate clinical response to these varied interactions requires a somewhat systematic way of considering these matters. One such schema has been suggested. ★★★

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References

1. Lalli, A. F. and Greenstreet, R.: Reactions to contrast media: Testing the CNS hypotheses. Radiology 138:47-49, Jan. 1981.
2. Doppman, J. L., Popovsky, M. and Girton, M.: The use of iodinated contrast agents to ablate organs: Experimental studies and histopathology. Radiology 138:333-340, Feb. 1981.
3. Lalli, A. F.: Contrast media reactions: Data, analysis, and hypothesis. Radiology 134:1-12, Jan. 1980.
4. Brasch, R. C. and Caldwell, J. L.: The allergic theory of radiocontrast agent toxicity: Demonstration of antibody activity in sera of patients suffering major radiocontrast agent reactions. Invest. Radiology 11:347-356, Sep.-Oct. 1976.
5. Cho, K. J. and Thornbury, R. R.: Severe reactions to contrast material by three consecutive routes: Intravenous, subcutaneous, and intraarterial. Am. J. Roentgenol. 131:509-510, Sep. 1978.
6. Lalli, A. F.: Urographic contrast media reactions and anxiety. Radiology 112:267-271, Aug. 1974.
7. Fischer, H. W. and Doust, V. L.: An evaluation of pretesting in the problem of serious and fatal reactions to excretory urography. Radiology 103:497-501, June 1972.
8. Abildskov, J. A.: The nervous system and cardiac arrythmias. Circulation 52 (6 supp 3):116-119, Dec. 1975.
9. Weiss, S. and Ferris E. B.: Adams-Stokes syndrome with transient complete heart block of vagovagal reflex origin; mechanism and treatment. Arch. Int. Med. 54:931-951, Dec. 1934.
10. Lasser, E. C., Walters, A. J. and Lang, J. H.: An experimental basis for histamine release in contrast material reactions. Radiology 110:49-59, Jan. 1974.

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A View of the Legislative Process

BUCKY MURPHY

NOT TOO MANY YEARS AGO, health was not a high priority item for the Mississippi Legislature. This is not to imply in any way that legislators were not interested in the public's health, but merely that most health-related matters were controlled almost totally by the private sector. With the coming of age of federal funding and state medicaid programs, health began to emerge as higher priority legislation. Now, there is intense competition for the federal and state dollar, not only between health and education and highways, but also among health related groups for their slice of the health-dollar pie.

Although there were hundreds of people around the interim capitol during the past legislative session, this article is about a relatively small group of people who have a tremendous amount of influence on health legislation. Not all of this group are even elected officials. They are: Brad Dye, Buddie Newman, Ed Ellington, Don Richardson, Glen Deweese, Ed Perry, Martin Smith, Perrin Purvis, John Hampton Stennis, Stone Barefield, Teddy Millette, Jim Simpson, Frank Barber, Charlie Hills, Sam Cameron, Martha Carol White, Clifford Thompson and Jan Rogers.

Role of Elected Officials

Perhaps a question has arisen already as to why the governor's name was not mentioned. Prior to discussion of persons in the legislative arena, we should examine the role of the governor in the legislative process. The governor in this state is not as powerful in the legislative arena as most of the people listed above. He cannot succeed himself. He has no vote, no authority over committees and no say on which bills will be discussed. He has veto power and personal influence with many of the legislators. The former can be overridden by the legislators and the latter usually fades with passage of his four year term of office.

Getting down to the nuts and bolts of legislation, let's examine the roles played by the people mentioned earlier. Undoubtedly some of the names listed above are familiar to many of you. What you may not be so familiar with however, is the life or death power some of these people have over health related bills. In taking a closer look, let's start at the top with Lt. Governor Dye and Speaker Newman. Dye, of course, is elected statewide and is a full time public official, assuming the duties of the governor's office when the governor is out of the state. Newman, a Valley Park farmer, is elected from his house district and serves as Speaker by virtue of election to that office by his colleagues in the House. His job is essentially full-time, requiring him to be in Jackson more than Valley Park. One of the most important functions these two men perform is the appointment of committees and committee chairmen. Because every bill is referred to a committee (sometimes two), the makeup of the committee is extremely important. Of equal importance is the authority that Dye and Newman have to refer bills to committees. It is completely within their power to send any bill to any particular committee or committees.

Role of Committee Chairmen

The second line of key people in the legislature are the committee chairmen. Of primary importance are Don Richardson and Ed Ellington, who chair the Public Health Committees in the House and Senate. Both of these men represent districts in Hinds County. Richardson is an educator and realtor while Ellington is an attorney. Their legislatively connected responsibilities extend beyond the session as both are members of the Mississippi Medicaid Commission. To these men fall the responsibility of naming subcommittees and assigning bills to those subcommittees for consideration. Most bills are considered first in subcommittees, and the makeup of these groups is of such importance that it cannot adequately be stated. The easiest place to kill a bill is in subcommittee, as evidenced by the death of the optometry bill in the House for the past two years. This year that bill was not referred to a subcommittee in the Senate and was never called up by the chairman for discussion. Thus it died "in the chairman's pocket." The position of the chairman is also crucial

Mr. Murphy is assistant executive secretary and general counsel for MSMA.

A relatively small group of people have a great amount of influence on health legislation in Mississippi. The author describes the roles played by some of those influential people in this discussion of the legislative process.

in securing passage of a bill because he is the one person who determines which bills will be brought up and discussed by the committee. Additionally, the political philosophy of the chairman is important, especially as it relates to organized medicine and medical legislation.

Glen Deweese and Ed Perry, as chairmen of the Appropriations Committees, are in a position to have life or death say over anything which requires state funding. Deweese, a Meridian businessman who owns a chain of convenience stores, and Perry, an Oxford attorney, serve on the Medicaid Commission along with Richardson and Ellington. The state funds for Medicaid, charity hospitals, and construction of new facilities such as the proposed perinatal center at the UMC come from their committees. The power of these men was exemplified in the 1980 session when the House Appropriations Committee failed to fund the charity hospitals. Deweese, who has a charity hospital in his district, simply sent word to the House that if his hospital didn't get funded, nothing else would either. The House took appropriate remedial action immediately.

Medico-legal bills usually are referred to the Judiciary Committees chaired by Martin Smith in the Senate and John Hampton Stennis (judiciary A) and Stone Barefield (judiciary B) in the House. All three are attorneys with Smith being from Poplarville, Stennis from Jackson, and Barefield from Hattiesburg. It is through these men that malpractice reform legislation must pass. All three are skillful in the way they handle their committees. Very seldom do any of these committees pass something the chairman does not support wholeheartedly.

Perrin Purvis of Tupelo and Teddy Millette of Pascagoula are both in the insurance business and chair insurance committees in each Chamber to which many bills of interest to the medical profession are referred. Bills dealing with mandated benefits under insurance policies, workmen's compensation, and cost containment are usually referred to these committees. Both Purvis and Millette run their committees as strongly as any chairmen in the legislature.

Jim Simpson of Long Beach chairs the Rules Committee in the House. It is this committee's responsibility to "set the calendar" once bills are reported to the full House. The importance of setting the calendar (the order in which bills will be taken up by the House) was clearly demonstrated several years ago when the optometry bill passed out of committee. The Rules Committee (chaired by George Payne Cossar at the time) kept it at the foot of the calendar where it died because it never got considered. Simpson's counterpart in the Senate is Lt. Gov. Dye, who has the power to influence the calendar in addition to his already mentioned other powers.

Although the power of the chairman can be felt on every committee, that does not necessarily mean that his control is absolute. On rare occasions, a bill is "polled out" of committee by a special vote of the entire House or Senate. And while a chairman can put a bill "in his pocket" and kill it, this is not frequently done because in many cases, the chairman will need the votes of other legislators to pass a bill he is interested in, so he does some "horse trading." Most legislators recognize the fact that politics is the art of compromise and thus, they avoid as much as possible making other legislators mad.

In addition to these people, there are numerous other legislators who play a key role in health related legislation. The list of names of these legislators would be too long to set out in this article. However, it is sufficient to note that relatives of physicians, nurses, chiropractors, optometrists, etc. all serve in the legislature and can be seen "working" the other members of specific bills which affect these various interest groups.

Role of Lobbyists

Now that we have mentioned the elected officials who play a key role in health related legislation, let's examine some non-elected people who exert a great amount of influence on these issues. Charlie Hills represents the chiropractors in the legislature and has a hard-core group of senators and representatives who will work when he gives them the signal. In recent years, chiropractors have successfully lobbied for mandatory reimbursement under insurance contracts for services they are lawfully authorized to perform, while unsuccessfully attempting to put a chiropractor on the Board of Medical Licensure and to expand the scope of their practice. Martha Carol White, a former member of the House, represents the nursing home industry. Nursing home administrators have a tremendous grass-roots lobby and re-

spond with calls and letters when requested. They have managed to keep from feeling the axe on reductions in services paid for by Medicaid. Clifford Thompson represented several groups in 1981, one of which was the optometrists. Because he lobbies for diverse groups, he has a good rapport with almost all of the legislators. Likewise, Frank Barber represents several groups, (the physician assistants in 1981, optometrists in 1980 as well as non-health related groups) and is extremely effective in organizing his groups to bring about a strong grass-roots effort. This was evidenced in the 1981 Session when he had more than 150 people from rural parts of the state show up at a hearing in support of P.A. licensure. Sam Cameron, who represents the Mississippi Hospital Association, is effective on health related matters, as is Jan Rogers of the Nurses Association. Both get good response from their membership when requested. Rogers can fill the Capitol with nurses at the drop of a hat. Cameron has been lobbying for a number of years and enjoys an excellent relationship with the legislators. These are only a few of the lobbyists who patrol the halls of the Capitol on a daily basis during the session. There are many others, all seeking to influence in some way items of legislation that have an effect on the practice of medicine.

Role of MSMA Members

Fortunately, MSMA has a good rapport with the legislative leaders named above. They are with us more often than they are against us. However, the increased pressures put on legislators by some of the interest groups mentioned above as well as many other groups often leads to results that are not as favorable toward organized medicine as we would want. The key to medicine's future rests with you and your relationship to your elected officials. Now, more than ever before, you must do your part — namely, get to know, support, and talk to your local legislators.

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Medicaid Looks at Reductions In Benefits, Payments, Eligibility

CHARLES MATHEWS and PATSY SILVER

PRESIDENT REAGAN has proposed cuts in federal funding for Medicaid, Health Professions Training and Categorical (Health) Grant Programs. To determine just what effect these proposed cuts might have in Mississippi, JOURNAL MSMA recently interviewed Mr. Billy F. Simmons, Director of the Mississippi Medicaid Commission; Dr. Norman A. Nelson, Vice-Chancellor and Dean of the University of Mississippi School of Medicine; and Dr. Alton B. Cobb, Executive Officer of the Mississippi State Board of Health. This month's JOURNAL presents the interview with Mr. Simmons. Subsequent issues will contain interviews with Dr. Cobb and Dr. Nelson.

Editorial Note: The Reagan Administration is seeking to cut federal expenditures for Medicaid by $100 million this year and to provide only a 5 percent increase in federal expenditures in fiscal 1982. Thereafter, increases in federal expenditures would be limited to the overall rate of inflation. Along with the proposed cuts in federal expenditures would come increased flexibility for the states to determine eligibility, scope of benefits and methods of reimbursement for their respective Medicaid programs. Also, Mr. Reagan has promised strong efforts to stop fraud and abuse in all federally funded programs.

JOURNAL MSMA: Mr. Simmons, what do you see as the financial impact on the Mississippi Medicaid Program of President Reagan's proposed cuts in federal funding for Medicaid?

SIMMONS: Financially speaking, it will mean a reduction of about $19 million in federal funds for our state programs in fiscal year 1982, which when combined with the state's matching money, means about a $25 million total reduction in funding.

JOURNAL MSMA: What do you see as Mississippi's and other states' alternative(s) to this cut in federal funding?

SIMMONS: There are only four. The states can either provide more funding which won't be matched by federal funds, or they can reduce benefits, lower payments and cut eligibility.

JOURNAL MSMA: What do you think might happen in Mississippi?

SIMMONS: Well, first of all, in the light of today's economy and mood of the people toward more taxes, I don't see any great amount of additional state funding to make up for lost federal funds. We will therefore have to look for reduced benefits, payments and eligibility.



JOURNAL MSMA: Where would you look first?

SIMMONS: On benefits and payments we will have to look at hospital, nursing home, physician, and drug services because that's where 90% of the current budget is being expended.

JOURNAL MSMA: What would be some of the possible changes in these services?

SIMMONS: I think we will see such things as prospective reimbursement for hospital services, bulk purchasing of certain services such as durable medical equipment and laboratory services, competitive bidding for physician and hospital services, limitations on nursing home services, development of and reimbursement for alternatives to institutional care, and development of reimbursement incentives for physicians who treat patients on an outpatient basis.

JOURNAL MSMA: Won't this mean an end to "freedom of choice" in selection of providers by Medicaid recipients?

SIMMONS: Yes. I think we will see Medicaid recipients going to selected Medicaid providers.

JOURNAL MSMA: What about restrictions on eligibility?

SIMMONS: I think it will become harder to qualify for Medicaid, and there will be more required in the way of co-payments by recipients for Medicaid services.

JOURNAL MSMA: What do you see as some of the positive aspects of the proposed changes in the Medicaid program from an administrative standpoint?

SIMMONS: Well, I hope that eligibility and benefit standards can be simplified. It now takes two or three lawyers to track and interpret these standards. I also hope we can see some alternatives to the present institutional care the program provides. For example, maybe we can reimburse day care centers where working adults can drop their elderly parents off on their way to work and pick them up in the evening, instead of putting them in



a nursing home. Also, I would like to see what we can do in the way of recognizing and rewarding providers for quality and cost efficient services.

JOURNAL MSMA: We hear a lot about fraud and abuse in the Medicaid Program. What is the situation in Mississippi?

SIMMONS: Fraud — some. Quasi abuse — yes, perhaps. For example, it's hard for me to understand why during the first 60 days of the 12 physician-visit limit last year, 60 recipients used their limit and received an average of 23 procedures (i.e. lab, x-ray, etc.). During the next 60 days the same recipients received an average of 3.6 procedures.

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The President Speaking

The Finale

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

The annual session of the MSMA will be history before my final comments make the print. I would like to express to all of you, especially those of you who were not fortunate enough to make the coast meeting, my sincere appreciation and thanks for allowing me the privilege to serve as your president during the past year. Jean and I were warmly received wherever we went, and we appreciate it more than you will ever know.

I believe that we had a good year and hope that you concur. The theme of my year was involvement, not only in the medical world, but in the real world as well. I know that the MSMA will have a good year under the able leadership of Dr. R. Faser Triplett of Jackson — after all, I have trained him well through the years. We have all witnessed his leadership ability as president of MMFES since its inception. Good luck, Faser.

I have come to the conclusion that organized medicine has done a good job in just staying afloat as a private enterprise system during the past two decades of social unrest. This has been accomplished through good leadership at the executive levels; however, we might need to capitalize on the Marine recruitment slogan — there is a need for a few good men in organized medicine. These should be people on the local level who have it all together. This would ensure us that the correct words and thoughts always arrive at the executive level. Organized medicine, just like any other organization, needs all of its members for numbers and financial support, but when action is needed, this can best be done by a few well informed, unselfish individuals. I have faith and really believe that such people are available.

Each local Medical Society should strive to see that some of their leaders attend the Leadership Conference sponsored by the AMA in Chicago each year. Here they will participate with a thousand or so people from all parts of the country, most with the same problems. There is an attempt to find an answer. Also on hand will be some of the so-called leaders in the political, educational, and economic fields. This is a worthwhile experience, and if anyone comes away not motivated to some degree, then I believe he should have his vital signs checked as soon as he returns home.

There are many medical organizations including some specialty

(Continued on page 128)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 5

MAY 1981

Developing Cancer Education And Control Programs

Today the management of patients with cancer is complex. The pre- and postoperative treatment evaluation procedures have proliferated, therapeutic maneuvers are more extensive, and followup care involving radiotherapy, chemotherapy, reconstructive surgery, and rehabilitation procedures and devices are more sophisticated. Often they are effective in improving the enjoyment of a responsible life. Strong advocates exist for proved and/or adventuresome projects.

Today, we do not know the magnitude of our cancer problem, the needs of the community or the state, or the results of our therapeutic endeavors. Each community involved in the care of patients with cancer should ensure that hospital staffs are involved in programs designed to provide optimum care for the patient with cancer. With the needs and performances of clinical cancer programs identified throughout the state, the need for and the goals of a real Cancer Center capable of pursuing innovative clinical approaches and basic science level ideas would be very evident.

These factors emphasize the need for a strong program for education of the community hospital staff. Such programs must be backed by a dedicated group of physicians, nurses, administrators and others who serve as an advisory group in each hospital to assure attention by hospital trustees and the first line medical nursing staff to patients with cancer.

The backbone of such a program is the demonstration of pertinence to a particular hospital of any one educational endeavor. The presence of an efficient data bank, often called a cancer registry, provides current pertinent information for educational sessions oriented toward the cancer patient and toward better management of future cancer patients. The collaboration of several such programs will also allow collection of meaningful information about cancer in Mississippi and aid in discarding old ideas or acquiring new therapeutic techniques, personnel or equipment on a local, regional or state-wide basis.

The proper use of a well functioning patient care and followup system will identify the needs, problems, and many of the solutions for the cancer patient in the hospital and in the community. How does your hospital staff address the problems of cancer patients in your community?

Since 1913 the American College of Surgeons and the American Cancer Society have promoted parallel and often identical efforts in the development of cancer education and control programs in the community hospital, of which one essential component has been the cancer registry or cancer data bank. Consultation and planning for such a program is free. The benefits to patient care will pay for the efforts.

George V. Smith, M.D.
State Chairman
Field Liaison Programs
Commission on Cancer
American College of Surgeons

Guest Editorial

Doctors' Day

In the early days, it was not difficult to become a physician in Mississippi: Prospective medical students simply "attached" themselves to a practicing physician and made the rounds with him as he bled, blistered or purged his patients back to good health, or — failing that — sent them to an early grave.

Despite its obvious shortcomings, there was something to be said for such a primitive method of training new physicians. If it did nothing to enhance a prospective physician's intellectual grasp of medicine, it at least provided him with a certain amount of on-the-job training.

Thank goodness, though, that that archaic system no longer exists.

Only six years after the University of Mississippi Medical Department was organized in 1903, the

school could claim 39 students at its two-year clinical facility in Vickburg. The school's biggest competitor, the Mississippi Medical College in Meridian, was even more impressive. When the school was organized in 1906, its first-year enrollment exceeded 100. Although a glance at the school's rules and regulations offers a glimpse of what the faculty had to overcome — the school, for example, was forced at one point to ban firearms in the classroom — a honest effort was made to teach the fundamentals of anatomy and health care.

By the time the Mississippi Legislature saw fit in 1950 to establish the University of Mississippi Medical Center in Jackson, the state was well on its way to maintaining a first-rate medical community.

Today the Medical Center, which produces about 150 new physicians each year, is generally regarded as one of the most progressive and proficient teaching facilities in the South. Mississippi-trained physicians are second to none in the nation.

Perhaps today — designated as "Doctors' Day" in many states — is as good a time as any to stop and reflect on how far Mississippi physicians have come over the years. It is also a good time to reflect on the many positive contributions this state's physicians have made to society as a whole.

(Editor's Note: Reprinted from the March 30, 1981 Jackson Daily News.)

THE PRESIDENT SPEAKING / Continued from page 126

groups who would like to be the mouthpiece for organized medicine. That's OK with me as long as they represent what is best for our patients and medicine. It matters not what handle is placed on an organization. The sad side of the above story, from my observation, is that most of these groups are mimicking an old political hack. They criticize their opponents, but have no worthwhile program of their own. Most are existing to preserve their own turf. We will not always get results that please everyone. If everyone is pleased, then no one profits. It takes different strokes for different folks. We must work for a common goal, one that fulfills most of the needs for medicine and especially our patients.

The Board of Trustees of our medical society should be commended. I have never known a more dedicated group of individuals. Their attendance record is almost unbelievable. You must remember that these gentlemen are practicing physicians just like yourself who give of their time and resources for the betterment of medicine. We should also be proud of our State Medical Association and members. Approximately 80% of the physicians of Mississippi belong. This is a number we can be proud of. In fact, this is a goal that it would be well for the nation as a whole to shoot for. We can make our organization better, but it will take input from all of us.

Finally, I would like to say to all those people at the headquarters building in Jackson, thanks for making the past year one which will be most memorable in my life. To my partners, thanks for putting up with me and a double thank you for not reducing my salary.

You Are Making a Difference

"You are making a difference — and it shows!" That is the report from the National High Blood Pressure Education Program of the National Institutes of Health, issued as High Blood Pressure Month begins.

In 1973, only 13% of Americans knew that high blood pressure is a major cause of heart disease. Today, almost twice that many relate high blood pressure to heart trouble. And a growing number of people now know that high blood pressure leads to strokes and kidney failure.

But the national effort to control high blood pressure is not finished. Many people do not stay on therapy, many hypertensive patients have not been identified, and many people still have misconceptions about the disease. The Education Program urges continued efforts in the fight against high blood pressure.

LETTERS

Sirs: We have noticed a perceived increase in the incidence of cases of familial ovarian cancer.

A registry for the collation of cases of familial ovarian cancer has been established at Roswell Park Memorial Institute to evaluate: (1) the type of inheritance to assist physicians with genetic counseling; (2) the relationship to breast and endometrial carcinoma; (3) the relationship to environmental, geographical and racial factors; and (4) the histopathology of familial cases.

Inquiries regarding the clinical history of any family with two or more members with ovarian cancer may be addressed to the Familial Ovarian Cancer Registry.

M. Steven Piver, M.D.
Roswell Park Memorial Institute
666 Elm Street
Buffalo, NY 14263

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche)℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

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diazepam/Roche

Before prescribing, pleese consult complete product informetion, a summary of which follows:
Indicetions: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contreindiceted: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Wernings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usege in Pregnancy:* Use of minor tranquilizers during first trimastar should elmost always ba avoided bacause of incraasad risk of congenitel melformetions as suggested in saveral studies. Consider possibiility of pragnancy when instituting therepy; advisa patients to discuss therapy if thay intand to or do bacome pregnent.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension; changes in libido, nausea, fatigue, depression; dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosege: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.

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Medico-Legal Brief

Insurance Company Liable To Physician

An insurance company and an attorney breached a duty owed to a physician when they settled a malpractice suit against the physician without his consent, the New Jersey Supreme Court ruled.

The physician, a neurosurgeon, performed an arteriogram on a patient in the summer of 1968. In September 1970, the patient filed a malpractice suit against the neurosurgeon. He sought $3 million in damages, claiming that the arteriogram caused him to lose the use of his hands. The neurosurgeon's insurance company assigned an attorney to handle the defense, and the physician later signed a settlement consent form.

After signing the form, however, the physician learned from other physicians that the patient had been using his hands normally. Suspecting fraud by the patient, the physician then wrote to the attorney and stated that no settlement should be made. A $50,000 settlement was agreed upon despite the physician's attempt to revoke his prior consent. As a consequence, the physician's premiums were increased substantially.

In a suit against the insurance company and the attorney, the physician charged that the insurer breached its contract with him and that the attorney violated the attorney-client relationship. The New Jersey Supreme Court said that the physician's consent to settle the claim was revocable, since there was no contrary provision. The insurance company's settlement of the claim despite the revocation constituted a breach of the consent provision.

The attorney ignored the wishes of his client, the physician, and followed the wishes of his client, the insurance company. He violated his duty to the physician by not informing him of the conflict of interest between his two clients. The attorney's failure to withdraw from the case completely or terminate his representation of either the insurance company or the physician constituted actionable professional malpractice, the court said.

The neurosurgeon was entitled to a retrial and an opportunity to prove his damages, the court said. — *Lieberman v. Employers Insurance of Wausau,* 419 A.2d 417 (N.J.Sup.Ct., Sept. 15, 1980)

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CME Workshop Meets in Biloxi

More than 50 physicians, hospital administrators and CME coordinators attended a recent CME workshop at the Broadwater Beach Hotel in Biloxi. The workshop was sponsored by MSMA and the Louisiana Medical Society.

Meeting activities were coordinated by Dr. Edward M. Rehak, chief of pathology and CME chairman at Gulf Coast Community Hospital in Gulfport. Among many outstanding speakers and panelists at the meeting were Dr. Joseph S. Gonnella, associate dean and director of academic programs, Jefferson Medical College and Dr. Robert K. Richards, assistant dean and executive vice president, University of Michigan.

Dr. Gonnella spoke on "A Critical Look at Continuing Medical Education Today" and Dr. Richards spoke on "Using CME to Improve Hospital Care."

The workshop was the second annual CME conference participated in by the MSMA Council on Medical Education as part of the council's program to accredit intra-state medical organizations and institutions offering CME to physicians. Dr. William E. Godfrey, II, of Natchez serves as chairman of the Council.

Dr. John Busey Receives International Award

John F. Busey, director of medical education, Mississippi Baptist Medical Center, is the 1981 recipient of the Rhoda Benham Award medallion of the Medical Mycological Society of the Americas.

Nomination for the international award is based upon the physician's continuous, outstanding and meritorious contributions to medical mycology. The award was presented in recognition of Dr. Busey's dedication and enthusiasm for the study of systemic fungal diseases, primarily blastomycosis. He has published numerous papers both on the clinical and basic research aspects of mycological diseases, and he continues to make valuable contributions to the training of medical students, house staff and practicing physicians.

Dr. Busey received his M.D. degree from Tulane University in 1930. Following an internship at City Hospital in Mobile, AL, he did postgraduate clinical training at Massachusetts General Hospital and New York Post Graduate Hospital. During World War II Dr. Busey served as a medical officer in the European Theatre of Operation, at the 8th Field Hospital, several Evac hospitals and the 68th General Hospital. He obtained the rank of Colonel before his discharge in 1948.

For 36 years Dr. Busey was affiliated with the Veterans Administration. He served as director of professional services at the VA Hospital in Atlanta and as chief of the medical service at the VA Hospital in Jackson. He was a member of the Veterans Administration Cooperative Study Committee on Histoplasmosis and chairman of the Veterans Administration Study Committee on Blastomycosis.

Dr. Busey has been on the faculty of the University of Mississippi School of Medicine since 1955, serving as clinical professor of medicine since 1966. He is certified by the American Board of Internal Medicine, and is a member of Central Medical Society and Mississippi State Medical Association.

Greenville City Jail Receives AMA Accreditation



The Greenville City Jail has been awarded full two-year accreditation for its health care system by the American Medical Association. Ella Tardy, MSMA Jail Project Coordinator, presented the Certificate of Accreditation to Chief Robert Skinner. Also at the presentation were, from left, Stephen Selby, assistant jail supervisor; Lt. Charles James, jail supervisor; David B. Keddy, M.D., physician responsible for the jail; and Greenville Mayor W. C. Burnley.

Arizona Physician Presents Medical Grand Rounds at UMC



Dr. David S. Alberts, center, associate professor of medicine and pharmacology at the University of Arizona Health Sciences Center in Tucson, presented medical grand rounds at the University of Mississippi Medical Center. With him are (from left) Dr. Carl Evers, UMC professor of pathology and associate dean for academic affairs, and Dr. J. Tate Thigpen, UMC associate professor of medicine and director of the division of oncology.

UMC Conducts Third Annual Neurology Symposium



Dr. Kenneth P. Johnson, center, chief of neurology research at the Veterans Administration Medical Center in San Francisco and professor of neurology and pathology at the University of California at San Francisco, was on the guest faculty for the University of Mississippi Medical Center's third annual neurology spring symposium. With him are symposium coordinator Dr. Shri Mishra (left), UMC associate professor of neurology and chief of the neurology service at the VA Medical Center, and Dr. Robert Currier, UMC professor of neurology and chairman of the department.

NEW MEMBERS

BOURLAND, WALTER L., JR., Jackson. Born Tupelo, MS, July 26, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned Parkland Memorial Hospital, Dallas, one year; general surgery residency, University of Texas Health Science Center 1976-80; elected by Central Medical Society.

DOUVAS, STAVROS G., Jackson. Born Greece, July 4, 1939; M.D., Faculty of Medicine University of Athens, Greece, 1965; interned Northwestern University, Chicago, IL, one year; ob-gyn residency, same, 1972-74; elected by Central Medical Society.

DUFFY, PATRICK A., Natchez. Born New Orleans, Aug. 10, 1946; M.D., Louisiana State University School of Medicine Shreveport, 1976; interned Confederate Memorial Medical Center, Shreveport, one year; ophthalmology residency, University Medical Center, Jackson, MS, 1977-80; elected by Homochitto Valley Medical Society.

ENGLAND, LESLIE E., Natchez. Born Boston, MA., Nov. 30, 1949; M.D., Louisiana State University School of Medicine, New Orleans, 1975; interned Carraway Methodist Medical Center, Birmingham, AL, one year; internal medicine residency, same, 1976-78; elected by Homochitto Valley Medical Society.

FILES, JOE CLARK, Jackson. Born Ackerman, MS, May 24, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned UMC, Jackson, one year; internal medicine residency, same, 1973-76; hematology fellowship, University of Washington, Seattle, 1977-79; elected by Central Medical Society.

GILLIES, WILLIAM G., Magnolia. Born Cape Town, South Africa, Dec. 22, 1923; M.D., Louisiana State University School of Medicine, New Orleans, 1949; interned Jersey City Medical Center, N.J., one year; elected by South Central Medical Society.

GRACE, JAMES B., Ocean Springs. Born Canton, MS, Aug. 31, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned

UMC, Jackson, one year; otolaryngology residency, National Naval Medical Center. Bethesda, MD, 1972-76; elected by Singing River Medical Society.

Hicks, W. Merrill, Jr., Born Greenwood, MS, Jan. 8, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned Vanderbilt Hospital, Nashville, TN, one year; internal medicine residency, same, 1976-79; elected by Delta Medical Society.

Lin, Dorothy S., Jackson. Born Detroit, MI, Mar. 28, 1925; M.D., Shantung Provincial Medical College, Tsinang, Shantung, 1953; interned, same, one year; radiology residency, same, 1954-56; radiology residency, Philadelphia General Hospital, PA, Jan. 1976-June 1977; radiology residency, University of Pennsylvania Hospital, Philadelphia, July 1977-June 1978; elected by Central Medical Society.

Purvis, John Marvin, Jackson. Born Memphis, TN, Aug. 20, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Baptist Hospital, Atlanta, GA, one year; orthopedic surgery residency, same, 1975-76; orthopedic surgery residency, Texas Scottish Rite Hospital, Dallas, 79-80; elected by Central Medical Society.

Sauls, Jeffrey L., Ocean Springs. Born Houston, MS, Feb. 9, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Queen's Medical Center Honolulu, one year; radiology residency, UMC, Jackson, MS, 1971-72 and 1974-76; elected by Singing River Medical Society.

Shaw, Rebecca D. L., Pascagoula. Born Decorah, IA, June 13, 1949; M.D., University of Iowa College of Medicine, Iowa City, 1975; interned University of Iowa, Iowa City, one year; ob-gyn residency, same, 1976-79; elected by Singing River Medical Center.

Stout, Marshall J., Jr., Jackson. Born Jackson, MS, Jan. 19, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned UMC, Jackson, one year; elected by Central Medical Society.

Tarpy, Patrick E., McComb. Born Shreveport, LA, Mar. 22, 1949; M.D., Louisiana State University School of Medicine, New Orleans, 1975; interned UMC, Jackson, MS, one year; pediatric residency, same, 1976-78; elected by South Central Medical Society.

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**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

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TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads
Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
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ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
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DEATHS

KING, JACK V., Jackson. Born Pelahatchie, MS, Jan. 22, 1923; M.D., Harvard Medical School, Boston, 1947; interned Grady Memorial Hospital, Atlanta, one year; residency in surgery, Ochsner Foundation Hospital, New Orleans, 1948-49; surgery residency, Grady Memorial Hospital, Atlanta, 1950-53; died March 7, 1981, age 58.

LAMB, WOODROW MCDONALD, Greenwood. Born Beech Grove, AR, Dec. 28, 1912; M.D., Tulane University School of Medicine, New Orleans, 1938; interned Missouri Baptist Hospital, St. Louis, one year; ob-gyn residency, Chicago Lying In Hospital, Chicago, June-Sept. 1940; died Feb. 25, 1981, age 68.

HULETT, ALEXANDER W., Charleston. Born Meridian, MS, July 17, 1922; M.D., Tulane University School of Medicine, New Orleans, 1950; interned John Gaston Hospital, Memphis, one year; died March 4, 1981, age 58.

PERSONALS

ROBERT L. BUCKLEY, JR. and JACOB SKIWSKI of Columbus announce the relocation of Columbus Children's Clinic to Doctor's Park, 425 Hospital Drive.

JOHN D. BURK of Tupelo has been named a diplomate of the American Board of Dermatology.

CLIFTON C. CARTWRIGHT of Booneville, LINDA CHIDESTER of Mantachie, THOMAS HOUSTON of Jackson, and RICHARD H. STREIFFER and WILLIAM EDWARD WALKER, both of Collins, have been named diplomates of the American Academy of Family Physicians.

DAVID L. CLIPPINGER has been named chief of staff at Garden Park Community Hospital in Gulfport. BEVERLY MYERS was appointed chief of medicine, and WILLIAM SEIDENSTICKER was named chief of surgery.

Columbus Orthopaedic Clinic (WILEY C. HUTCHINS and CHARLES S. RHEA, JR.) has relocated to 2459 Fifth Street North in Columbus.

CLAUDE EARL FOX of Jackson served as chairman for the Maternal-Child Health Workshop at the recent national meeting of State Maternal-Child Health and Crippled Children's Directors in San Diego, CA.

JOHN G. GASSAWAY of Starkville was inducted as a fellow of the American Academy of Orthopaedic Surgeons at the group's 48th annual meeting in Las Vegas.

JAMES HARDY of Jackson and UMC represented the American College of Surgeons at the annual meeting of the Association of Operating Room Nurses in Dallas.

BOBBY J. HEATH of Jackson and UMC has been named to the Board of Governors of the American College of Cardiology.

MICHAEL E. JABALEY recently spoke at meetings of the Chicago Hand Society, the Rocky Mountain Hand Society and the New York Society for Surgery of the Hand, and was a faculty member at a hand surgery course sponsored by Rush-Presbyterian-St. Luke's Medical School.

JOHN JACKSON of Jackson and UMC recently conducted a seminar at the National Institutes of Health in Bethesda, MD.

HERBERT LANGFORD of Jackson and UMC recently served as a panelist at a meeting of the American College of Physicians in New Orleans and conducted a workshop on hypertension at the North Mississippi Medical Center.

RONALD R. LUBRITZ of Hattiesburg announces the opening of his Meridian office for the treatment of diseases and tumors of the skin, located at 1525 22nd Avenue.

LEO SCANLON of Vicksburg was guest speaker at a recent meeting of the Vicksburg Rotary Club.

KELLY S. SEGARS of Iuka recently spoke to the Flying Physicians Association in St. Anton, Austria, on "Coronary Care in the Rural Hospital."

ROBERT J. TRAUTMAN, JR., announces the opening of his office for the practice of dermatology at 2200 South Lamar in Oxford.

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Continue therapy with
Anusol®
Suppositories/Ointment
to help maintain relief of hemorrhoidal or other anorectal symptoms

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Soothing, cooling
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Premoistened hemorrhoidal/vaginal pads
for temporary relief of occasional external anorectal itching/burning and regular hygienic care.

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POSTGRADUATE CALENDAR

July 23-25, 1981
ADVANCED CARDIAC LIFE SUPPORT
Meridian, Mississippi

October 14-17, 1981
FAMILY PRACTICE UPDATE
Jackson, Mississippi

December 10-11, 1981
PERINATAL POSTGRADUATE COURSE
Jackson, Mississippi

For more information, contact the Division of Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

Conference on Aging Scheduled in New Orleans

Physicians are invited to attend "Aspects of Aging II," a conference sponsored by the Veterans Administration Medical Center in New Orleans on May 22. The program will begin at 8:00 a.m. and conclude at 1:00 p.m.

Guest speakers will include Ian M. Smith, M.D., professor of medicine, University of Iowa School of Medicine, and William E. Fann, M.D., professor of psychiatry and associate professor of pharmacology, Baylor College of Medicine. In addition, Robert Burch, M.D., the Price-Goldsmith Professor of Nutrition at Tulane, will speak.

Medical Grand Rounds will be included as part of the program. Category I Credits will be offered. There is no registration fee.

For information, contact Daniel K. Winstead, M.D., VA Medical Center, 1601 Perdido Street, New Orleans, LA 70146.

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Next Month in Journal MSMA

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
Otitis media caused by S. pneumoniae (formerly D. pneumoniae) and H. influenzae
Acute exacerbation of chronic bronchitis caused by H. influenzae*
*Though clinical improvement has been shown, bacterialogic cures cannot be expected in all patients with chronic respiratory disease due to H. influenzae.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.
URINARY TRACT INFECTIONS caused by E. coli and P. mirabilis. (This drug should not be used in any E. coli and P. mirabilis infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.
Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.
Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytapenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

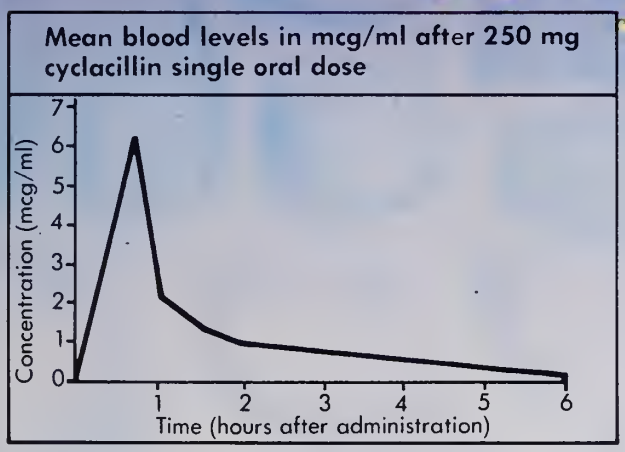
*Dosage should not result in a dose higher than that for adults
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Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*





- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{α} ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by S. *pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W

(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

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The first prescription for the first days of acute pain

Empirin® c̄ Codeine #3

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). Ⓒ III

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin c̄ Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming.) Ⓒ III

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 7-11, 1981, Chicago; James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 113th Annual Session, April 26-30, 1981, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 29-August 1, 1981, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
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735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community Gulfport Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Howard Memorial Hospital
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

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PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

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PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

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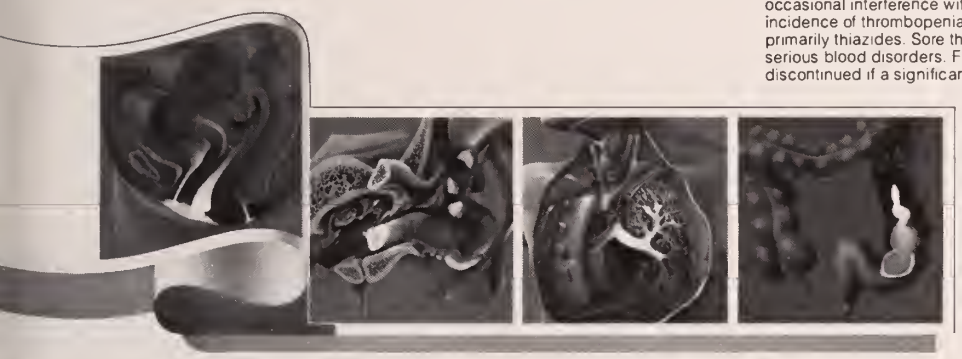
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Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

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in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

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PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med 303* 426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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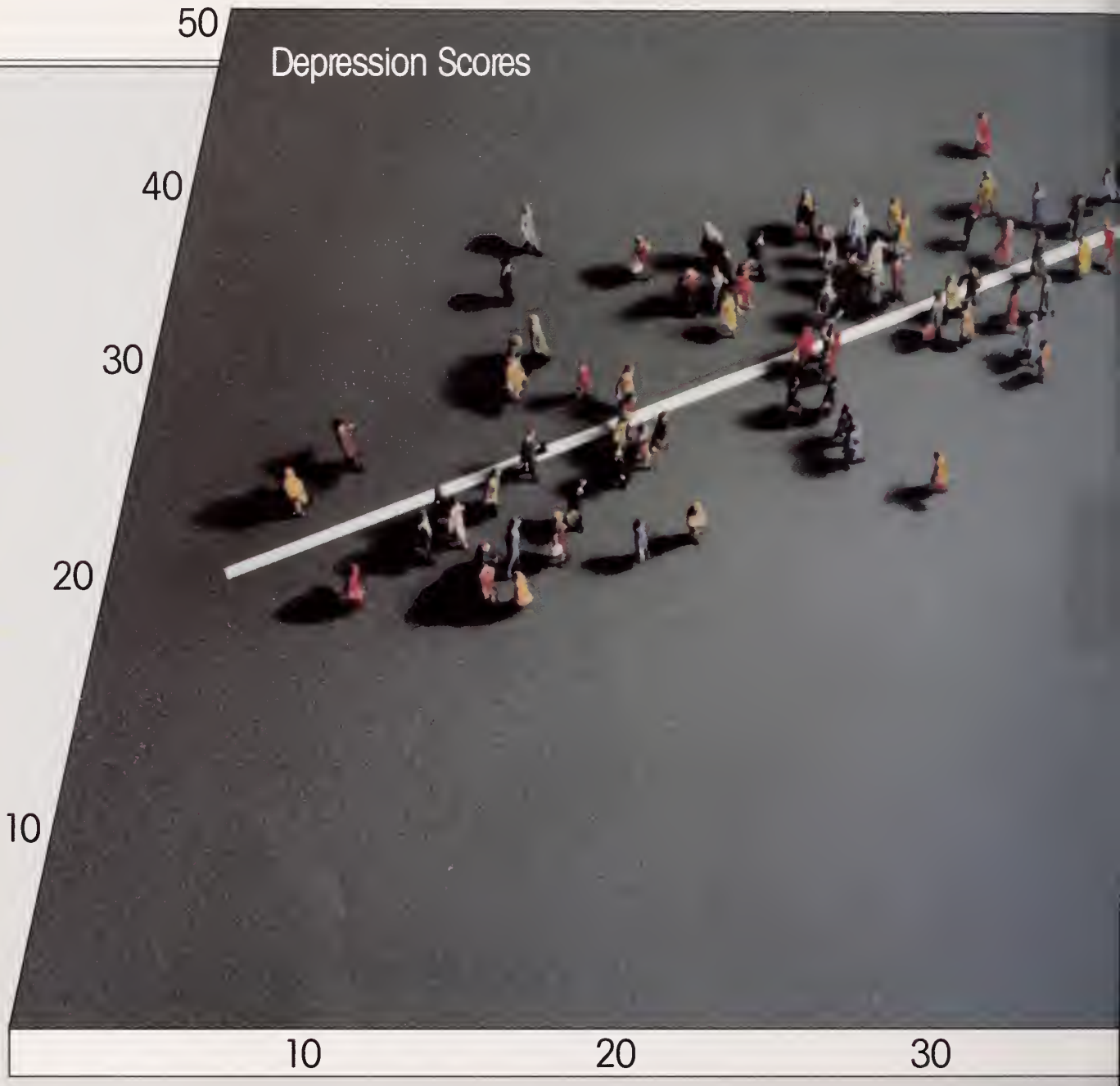
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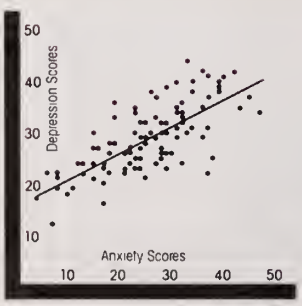
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R. Faser Triplett, M.D. — MSMA President, 1981-82

FOR THE 7 OF 10 NONPSYCHOTIC





Clear correlation between anxiety and depression[3]

The obave graph illustrates o relationship between onxiety and depression, indicating thot patients seldom present with onxiety or depression alone; more often they hove both in varying degrees. Data based on a sampling of 100 outpotients (64 male; 36 female) seen at o general psychiatric clinic.

[3]Adopted from Cloghorn, J. The anxiety-depressian syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]



Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

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Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* ed. Jarvik ME. New York, Appleton-Century-Crafts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35:*1359-1365, 1978. **3.** Clagharn J: The anxiety-depression syndrome. *Psychosomatics 11:*438-441, 1970. **4.** The Task Force on Late Neuralagical Effects of Antipsychatic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137:*1163-1172, 1980. **5.** Feighner JP *et al:* A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61:*217-225, 1979.

In moderate depression and anxiety

Limbitrol® IV

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Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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June 1981, Volume XXII, Number 6

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Dr. John Bickers (right), professor of medicine and chief of the medical oncology section at Louisiana State University School of Medicine in New Orleans, was a guest speaker for the University of Mississippi Medical Center's update on neoplastic disorders. With him is seminar coordinator Dr. Francis Morrison, UMC professor of medicine and director of the division of hematology. Sponsors were the UMC School of Medicine Department of Medicine and the Medical Center Division of Continuing Health Professional Education. Partial support was provided by Beecham Laboratories, a Cancer Education Grant of the National Cancer Institute and the Dameron Friley Spruill and Wilma Fay Spruill Memorial Lecture in Oncology Fund of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

UMC Announces Faculty Appointments

Six new faculty members have joined the centerwide and School of Medicine faculties at the University of Mississippi Medical Center in Jackson.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Joining the School of Medicine faculty are Dr. James Edward Peck, assistant professor of surgery (otolaryngology); Dr. Ramon P. McGehee, assistant professor of obstetrics and gynecology; Robert Cooksey, instructor in medicine (research); and Dr. Kiyoshi Takahashi, instructor in medicine (research).

Joining the centerwide faculty are Dr. Coral Lamartiniere, associate professor of pharmacology and toxicology, and Dr. Richard S. Nowakowski, assistant professor of anatomy.

Dr. Peck has been associate professor of human communication at Creighton University School of Medicine in Omaha since 1977 and an audiologist at Boys Town Institute for Communication Disorders in Children there since 1976. He earned the B.A. and M.A. degrees at the University of Connecticut and holds a Ph.D. from Vanderbilt University.

Dr. McGehee has been a fellow at M. D. Anderson Hospital and Tumor Institute since 1979. He holds a B.S. degree from Millsaps College. He earned the M.D. and took residency training at the University of Mississippi Medical Center.

Cooksey holds the B.S. and M.S. degrees from Jacksonville State University. He had been research assistant for the Diabetes Research and Training Center and Thyroid Research Laboratory at the University of Alabama since 1979.

Dr. Takahashi, research associate in the division of hematology and oncology at Scripps Clinic and Research Foundation in La Jolla, CA, since 1979, earned the M.D. degree at Okayama University Medical School in Okayama, Japan. He took residency training at Kobe Red Cross Hospital in Kobe, Japan, and was an instructor in medicine at Okayama Medical School from 1978-1979.

Dr. Lamartiniere earned the B.S. and Ph.D. degrees at Louisiana State University and did postdoctoral work at the University of Texas Southwestern Medical School. A former research associate in biochemistry and obstetrics and gynecology at Columbia University and Roosevelt Hospital in New York City, Dr. Lamartiniere has been senior staff fellow in the Laboratory of Organ Function and Toxicology at the National Institute of Environmental Health Sciences in North Carolina since 1976.

Dr. Nowakowski was with the department of neurobiology at the Max Planck Institute for Biophysical Chemistry in West Germany before joining the Medical Center faculty. He earned the B.A. degree at the University of Wisconsin and the Ph.D. at Harvard. He took postdoctoral training at Harvard Medical School and Duke University.

114th Annual Session

May 2-6, 1982
Biloxi Hilton

Mark your calendars now, and plan to be there for the big 125th anniversary celebration!



Equagesic®©

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-ferm use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g , alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnency has been suggested in several studies. Because use of these drugs is rarely e metter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-beering potential may be pregnant at the time of institution of therapy should be considered. Petients should be advised that if they become pregnant during therepy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or neer maternal plesme levels and in breest milk of fectating mothers at concentrations two to four times that of meternel plasma. When use of meprobamate is contempleted in braast-feeding patients, the drug's higher concentration in breast milk as compered to meternal plasma levels should be considered.

Preparations containing aspinn should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuna Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses ere much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse end respiratory rates are reduced to basal levels Hypervantilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g , caffeine Metrazol or amphetamina, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may expenence nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspinn is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamata is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not hed a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are charactenzed by an itchy urticanal or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administretion of epinephrine, antihistamine, and possibly hydrocortisona Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly avery instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspinn have been reported These were accompanied by symptoms of CNS depression including drowsiness and lightheadedness with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropnate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspinn would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage specific paranteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspinn

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101



for mild to moderate pain

Wygesic®IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**)
Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS
The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity: jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Eliminate pinworm without dosage calculations



Compare: Vermox® vs Antiminth* and Povan†

Patient Weight

	40 lb	60 lb	80 lb	130 lb	150 lb	180 lb	200 lb
VERMOX	1 tab	1 tab	1 tab	1 tab	1 tab	1 tab	1 tab
Antiminth	4 ml	6 ml	8 ml	13 ml	15 ml	18 ml	20 ml‡
Povan Tablets	2 tabs	3 tabs	4 tabs	6 tabs	7 tabs‡	7 tabs	7 tabs

‡Maximum dosage

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug

Precautions PREGNANCY VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The VERMOX tablet may be chewed, swallowed or crushed and mixed with food For control of pinworm (enterobiasis) a single tablet is administered orally, one time If patient is not cured three weeks after treatment, a second course of treatment is advised

Rx

Vermox
Tabs #4
Sig 1 tab
each family
member

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Because VERMOX has not been extensively studied in children under two years of age, the relative benefit/risk should be considered before treating these children. VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug

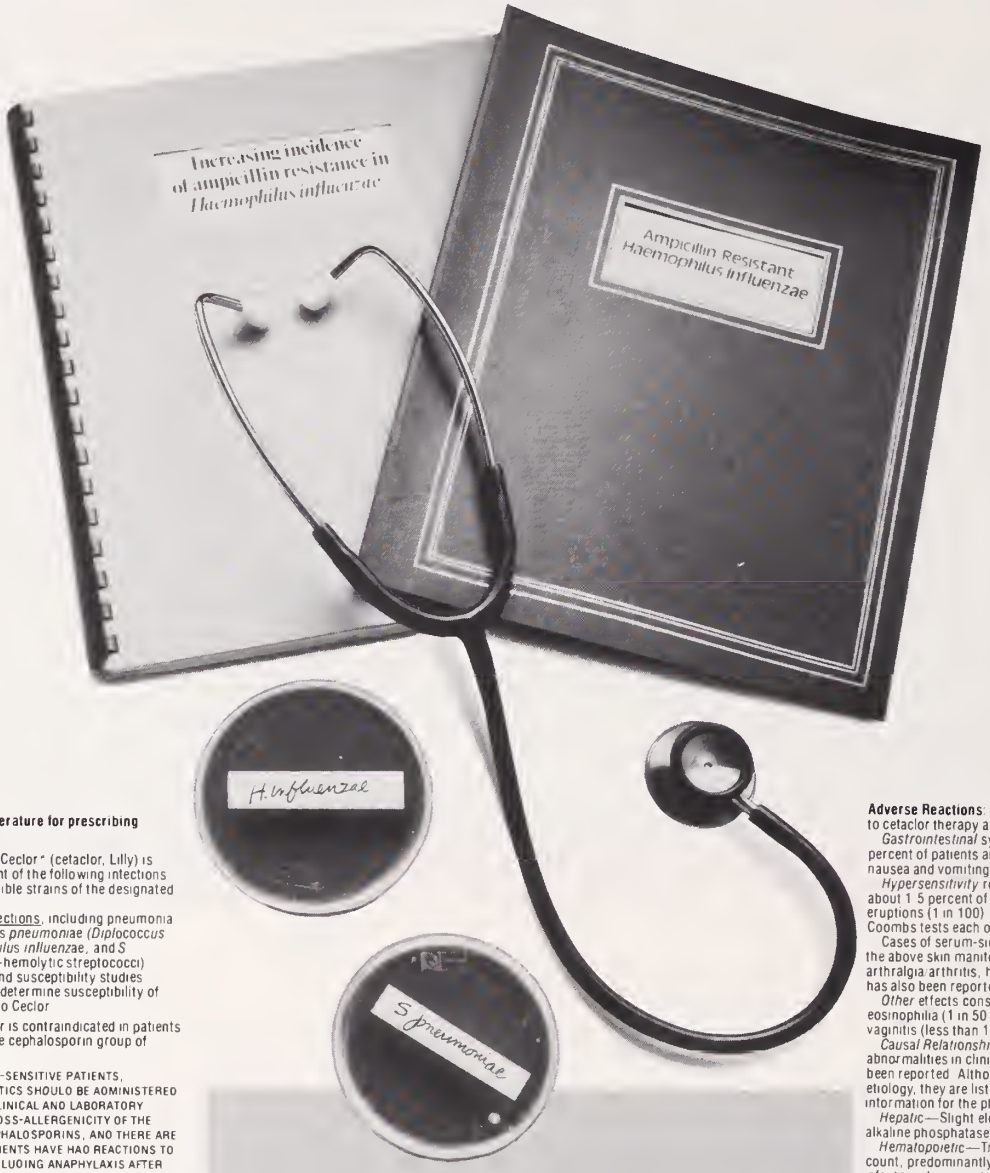
Just one tablet eliminates pinworm, regardless of patient age††and weight.

Vermox® CHEWABLE TABLETS (mebendazole)

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cetaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cetaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Caretul observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cetaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [1030BOR]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* *

Note Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information.

References

1 Antimicrob Agents Chemother , *8*: 91, 1975
2 Antimicrob Agents Chemother , *11*: 470, 1977
3 Antimicrob Agents Chemother , *13*: 584, 1978
4 Antimicrob Agents Chemother , *12*: 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother., *13*: 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr., and J E Bennett), p 487 New York John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Lilly

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Carolina, Puerto Rico 00630

100061

NEWSLETTER

June 1981

Dear Doctor:

The practice of smoking high-potency heroin and relatively low price of current heroin supplies may contribute to an increase in use of the drug among an affluent population that previously may have only experimented with cocaine inhalation, says a new book. Drug Abuse: A Guide for the Primary Care Physician, available from the AMA's Order Department, was compiled by the AMA Dept. of Mental Health to assist physicians in treating drug abusers among their patients.

> The book includes pointers on prescribing practices that will curb abuse of regular prescription drugs. Marijuana remains the most popular mind altering drug, and usage now often begins at a much earlier age and is more likely to be frequent. The book also reports that more than one million people use cocaine regularly.

According to the latest Office of Health Maintenance Organizations (OHMO) census, 21 new HMOs were started in 1980, and one million additional people joined prepaid plans. Eighteen of the new plans are IPAs. There are now 236 HMOs in the U.S., up from 215 in 1979. Enrollment totals 9.1 million, with 58.8% in the West, 18.2% in the North Central states, 16.9% in the Northeast, and 6.9% in the South.

Twelve federally qualified HMOs had folded as of March 1981, and another 43 have serious problems warranting federal monitoring and intervention. A federal project to assist failing HMOs found that the most serious problem facing the plans is deficiency in internal management, including difficulties in administration, finance, marketing, board of directors and delivery of care.

The FTC has pulled back from two of its most controversial health-related proposals. The commission has indicated intent to terminate a proposed rule which would have banned certain television advertising directed at children, particularly sugared food products. The Commission also decided it would not prohibit physicians from sitting on governing boards of Blue Shield and similar plans.

A revised policy of eligibility for the Physician's Recognition Award provides that all physicians holding a valid and current license issued by one of the U.S. licensing jurisdictions or who are engaged in an accredited residency training program in the U.S. may apply for the PRA, without regard to citizenship or membership in the AMA, state medical societies or medical specialty societies.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

More physicians *are coming to MMFES because MMFES does more for physicians.*

The active and involved physician has to rely on comprehensive insurance programs tailored to fit the day-to-day special needs of his profession.

One of these special needs is malpractice insurance. MMFES is a non-profit Mississippi Corporation sponsored by the Mississippi State Medical Association and directed by Mississippi physicians. MMFES offers comprehensive coverage on three types of malpractice insurance policies and it'll probably cost you less than other plans.

Mike Houpt is aware of your special need. Give him a call toll free at 1-800-682-6415 or 944-0072.

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Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine. Some of our better known products are Lopurin™ , Ru-Tuss® and Ru-Vert® . This advertisement highlights four other products particularly useful for the family.

F-E-P CREME® • SU-TON® • TWIN-K® • TWIN-K-Cl™



For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin—Pramoxine HCl—Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (½ ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.



For Potassium Supplementation Improved Compliance...

TWIN-K®

Each 15 ml supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

The good tasting potassium supplement

- Designed for prophylactic and therapeutic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient dosage aid patient compliance.
  The organic salt of potassium can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine.[1]

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, page 1959

In Cases with Chloride Deficiency...

TWIN-K-CI™

Each 15 ml supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride in a sorbitol and saccharin solution.

The good tasting potassium supplement with chloride

- In hypokalemic hypochloremic alkalosis, chloride ions are required. Twin-K-Cl is specially formulated to be a good tasting chloride containing potassium supplement.
- Contains no potassium chloride. Twin-K-Cl is a carefully balanced combination of organic potassium salts plus ammonium chloride.
- In hypochloremic patients, potassium should be provided as the chloride salt, or chloride ion must be made available in some other form, such as ammonium chloride or sodium chloride.[1]

See prescribing information on last page of this advertisement.



F-E-P CREME®

DESCRIPTION
F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma, nuchal eczema and chronic eczematoid otitis externa, acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris corporis, pedis); moniliasis; intertrigo. Final classification of the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS
Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS
This product is not for ophthalmic use.
In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY
Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS
F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period.
Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests. The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine.
Prolonged use of this drug may result in an overgrowth of non-susceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS
Skin rash or hypersensitivity may occur following topical application.
The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION
Apply a thin layer of the drug to affected parts 3-4 times daily.
Note:
1. F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED

F-E-P Creme	½ ounce (15 gm) tubes	NDC 0524-0026-51
F-E-P Creme Plain	½ ounce (15 gm) tubes	NDC 0524-0025-51

Federal law prohibits dispensing without a prescription.
July 1980

SU-TON®

DESCRIPTION
Forty-five milliliters of SU-TON contain the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE
SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS
Epilepsy; convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS
The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS
Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS
Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE
Drug dependence has not been reported with SU-TON.

OVERDOSAGE
Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.
Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION
One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED
Bottles of 473 ml (16 fl oz) NDC 0524-0015-16
Federal law prohibits dispensing without prescription.
February 1980

TWIN-K®

DESCRIPTION
Each 15 milliliter (one tablespoonful) supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

INDICATIONS AND USAGE
For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS
Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS
TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.
To minimize gastrointestinal irritation, it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS
Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.
The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.
Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.
In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS
Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.
TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE
The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes. Treatment measures include:
1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION
The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of potassium ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K are to be avoided.
Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED
Bottles of 1 pint (16 fl oz) NDC 0524-0021-16

CAUTION
Federal law prohibits dispensing without prescription.
July 1980

TWIN-K-CI™

DESCRIPTION
Each 15 ml (one tablespoonful) supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride, in a sorbital and saccharin solution.

INDICATIONS
For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Potassium and chloride are usually the salts of choice in the treatment of hypokalemia since chloride and potassium deficiencies are likely to be associated with each other.

CONTRAINDICATIONS
Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS
TWIN-K-CI is a palatable form of oral potassium replacement. Excessive, undiluted doses of TWIN-K-CI may cause a saline laxative effect.
To minimize gastrointestinal irritation, it is recommended that TWIN-K-CI be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS
Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.
The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.
Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.
In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K-CI is recommended for use in these patients.

ADVERSE REACTIONS
Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiograpic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.
TWIN-K-CI taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE
The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes.
Treatment measures include:
1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION
The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 30 to 60 mEq of potassium ions and 8 to 16 mEq of chloride ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K-CI are to be avoided.
Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED Bottles of 1 pint (16 fl oz)
NDC 0524-0022-16

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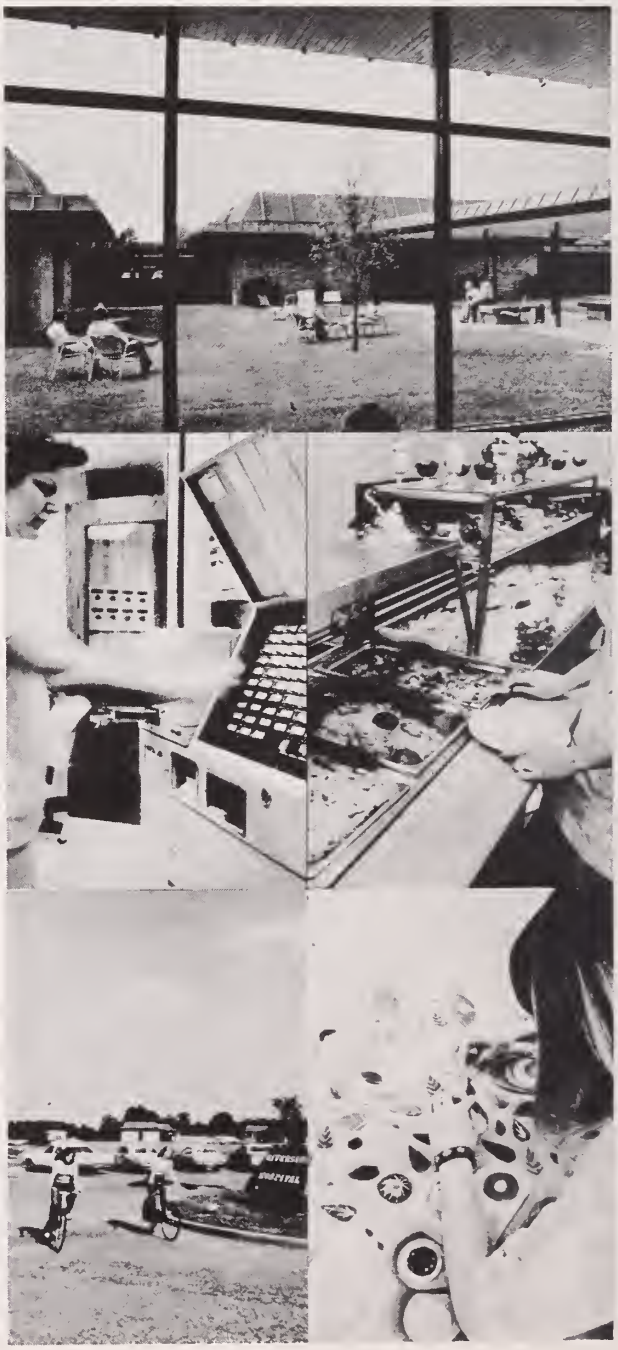
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

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Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

DATELINE

EMS Compiles Ambulance Survey

Jackson, MS - The first detailed survey of ambulance services in Mississippi has been compiled by the Division of Emergency Medical Services of the State Board of Health. The survey showed the companies operate an average of two units at an annual per unit cost of $22,294 and an average annual operating cost of $67,627; 87% reported a response time of less than 10 minutes; and 90% reported no legal claims had been filed against the company.

Restricted License For Charity Hospital

Jackson, MS - The Mississippi Health Care Commission granted a one-year, restricted license extension to Natchez Charity Hospital. The decision was made at the Commission's April 30 meeting. MHCC spokesmen stated that the hospital probably faces more frequent safety inspections. Under the restrictions no major surgery can be performed at the facility, and the license will not be renewed next year unless plans are underway to construct a new building.

Medical Schools Receive AMA-ERF Funds

Chicago, IL - This spring the nation's medical schools received a total of $1,282,599 from the AMA Education and Research Foundation. More than $30 million have been raised by AMA-ERF since the beginning of the Foundation. Indiana University School of Medicine received the largest grant this year, $55,556. Northwestern University Medical School of Chicago was second with $41,028. MSMA presented an AMA-ERF check to University of Mississippi School of Medicine in the amount of $22,857.

AMA Opposes National Technology Center

Chicago, IL - The National Center for Health Care Technology should be eliminated, the AMA has told a House committee. The AMA opposes reauthorization of the center "not out of a lack of concern for the safety, efficacy, and cost-effectiveness of medical care, but because the relevant clinical policy analysis and judgments are better made, and are being responsibly made, within the medical profession," said the AMA position statement.

Voluntary Standards For Alcohol Promotion

Chicago, IL - Proposed new federal restrictions on advertising and labeling of alcoholic beverages won't make much impact on the problem of alcohol abuse, the AMA commented to the Bureau of Alcohol, Tobacco and Firearms of the Department of the Treasury. Instead of rigid advertising rules the AMA proposed a voluntary collaboration between government agencies, industry and other interested parties in enforcing strict voluntary standards for promotion of alcoholic beverages.

Brandon Student Wins Pediatrics Poster Contest



A poster by Brandon resident Becky Barnett, right, will represent Mississippi in a national contest sponsored by the American Academy of Pediatrics. She was winner in the local contest sponsored by the Academy's Mississippi chapter. Dr. David Watson, center, professor of pediatrics at the University Medical Center, chairs the Academy's Mississippi chapter. Melissa W. Bondurant is Ms. Barnett's art teacher at Pearl High School. Ms. Barnett is the daughter of Mr. and Mrs. Bernard Barnett. Her poster entry depicts how to prevent childhood accidents.

Dr. Edgar Haber Presents Greganti Memorial Lecture

Dr. Edgar Haber, professor of medicine at Harvard Medical School, was the first Frank Paul Greganti Lecturer at the University of Mississippi Medical Center this spring.

Dr. Haber also is chief of the cardiac unit at the Massachusetts General Hospital in Boston. His topic was "Antibodies as Tools in Cardiovascular Research."

The lecture award was established as a memorial to the late Dr. Frank Paul Greganti, a cardiologist who died in 1977 at 44.

A native of Merigold, Dr. Greganti earned the B.S. summa cum laude at the University of Mississippi. He completed the first two years of medical school on the Oxford campus with the highest academic average in his class. He graduated from Harvard Medical School in 1957.

The lecture award is made possible by the Frank Paul Greganti Memorial Fund, established by Dr. Greganti's widow.

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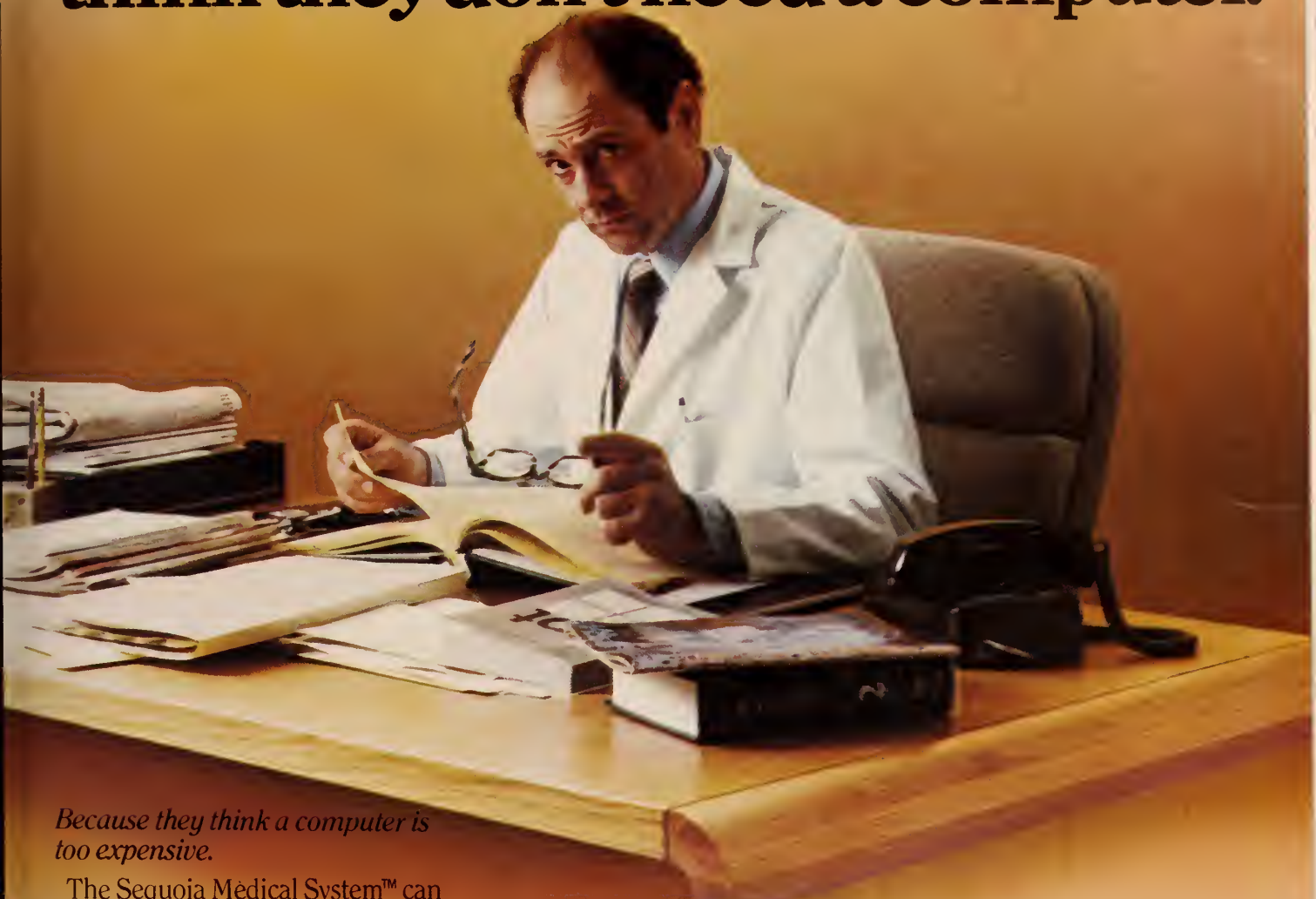
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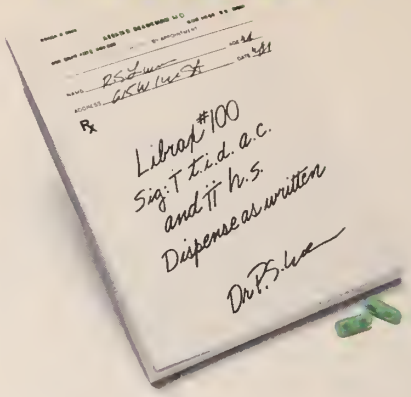
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Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema; minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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In Duodenal ULCER* MANAGEMENT



The proven antispasmodic and antisecretory actions of Quarzan® (clidinium bromide/Roche) for the ulcer

The well-known antianxiety action of Librium® (chlordiazepoxide HCl/Roche) for the accompanying anxiety found in many ulcer patients

Specify Adjunctive **Librax®** ROCHE®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

Antianxiety/Antisecretory/Antispasmodic

*Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on facing page.

Photograph of simulated gastric hypersecretion.



Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.

getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate® Dospan® ℂ℣
(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense. And it's responsible medicine.

Merrell

Tenuate® ℂ℣
(diethylpropion hydrochloride NF)

Tenuate Dospan® ℂ℣
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of January, 1980

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633
Direct Medical Inquiries to.
MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, Ohio 45215
Licensor of Merrell®

References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga, M.T. et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo–

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN*
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® (*cloxacillin sodium*)	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q 6h.

Children: 50 mg./Kg./day in equally divided doses q 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS

SUPPLIED:
Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
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Division of Bristol-Myers Company
Syracuse, New York 13201

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works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

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North Carolina 27709

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
June 1981, Vol. XXII, No. 6

ORIGINAL PAPERS

Rocky Mountain Spotted Fever in Mississippi: An Update on an Increasingly Common Infection

FRANK M. WIYGUL, JR., M.D.
Jackson, Mississippi

The number of reported cases of Rocky Mountain spotted fever has increased greatly both in Mississippi and in certain parts of the rest of the United States in the last ten years. The author reviews the clinical and epidemiological features of the disease and calls attention to the geographic distribution of cases within the state. He notes that two-thirds of the 117 cases reported in the last five years occurred in a group of 14 contiguous counties in north and northeast Mississippi, and he maintains that physicians practicing in that area should be aware of the apparent increased incidence of the disease.

ROCKY MOUNTAIN SPOTTED FEVER (R.M.S.F.) has been known to occur in Mississippi since the early 1930's when the first cases were reported in the state. For many years, cases occurred infrequently and were reported sporadically from various parts of the state with little indication of a change in the pattern of low level endemic occurrence. In fact, by 1960 the disease had reached such a low level of occurrence that only 380 cases were reported in the country. Then beginning about 1970 there was a large increase of reported cases in the United States. This was paralleled by an increase in cases in Mississippi as well (see Figure 2), with 30 cases being reported in 1976. Cases have been reported most frequently in 14 contiguous north and northeast Mississippi counties as shown on the map (see Figure 3) with two-thirds of the cases being reported from these counties in the last five years. The disease is both underdiagnosed and underreported in areas where it occurs, with studies indicating at least half of diagnosed cases are unreported.[1, 4, 5, 7, 8]

A severe exanthematous infection, Rocky Mountain spotted fever is caused by a rickettsial organism transmitted usually by the bite of the American Dog Tick *(Dermacenter variabilis)* in our area but may be transmitted by other hard bodied (ixodid) ticks as well. The disease is unusual in that the tick is both the vector of the disease and the primary reservoir for the causative organism, rickettsia rickettsii. The agent of the infection is passed from generation to generation of ticks through the eggs of the tick. Several species of ticks are known to transmit the causative organism to dogs and wildlife but rarely bite man. An exception in our area is the lone star tick which has been shown to transmit the agent and may be an important vector. Additionally, a large number of wildlife species can be infected and make up a secondary reservoir of infection.

The essential pathology of R.M.S.F. is lesions of the small blood vessels involving the skin, sub-

Presented at the Mississippi Baptist Hospital Pediatric Education Conference, August 12, 1980.
From the Department of Family Medicine, University of Mississippi Medical Center, Jackson, MS.

TYPHUS FEVER, TICK-BORNE (Rocky Mountain Spotted Fever) — Reported Case Rates by Year, 1950–1978



Figure 1

cutaneous tissue, nervous system and other organs of the body. Untreated, the disease usually runs a febrile course of about three weeks with a mortality rate of about 20%. It occurs more frequently in children, with two-thirds of the cases being under 20 years of age, but is more severe in adults. In treated cases the mortality is 5%-8%.[1]

After an incubation period of 5-7 days (range 3-12 days), the disease begins with a brief prodrome a few hours in duration with malaise, anorexia, headache and myalgia, followed by an abrupt onset of chills and fever with temperature to 104° or higher. A history of recent tick bite is present in about 60% of the cases with another 10% of the cases having had recent exposure to ticks through manual removal from dogs. The rash appears on the third or fourth day and is the most characteristic feature of the disease. The typical rash is maculopapular, beginning on the extremities, then spreading toward the body, the palms and soles also being involved. The rash usually becomes hemorrhagic or purpuric after one or two days and may become necrotic. In several published series of cases, authors have emphasized that the rash may be atypical and as many as 10% of the cases will have transient rash or no rash. Edema and circulatory collapse are clinical features of severe cases.

The differential diagnosis includes other febrile illnesses with a hemorrhagic or purpuric rash. The more frequently occurring of these are meningococcemia, rubeola, enterovirus infections and tularemia.

Definitive diagnosis is established by laboratory demonstration of acquired specific antibodies. Both the Weil-Felix reaction and the complement fixation test are used for this purpose, with the complement fixation reaction being more specific and more reliable. The Weil-Felix reaction, an agglutination reaction to certain strains of Proteus organisms, is less specific and more subject to both false negative and false positive reactions. Paired specimens of acute and convalescent serum should be submitted. A complement fixation reaction with a single titer of 1:16 or a fourfold rise in paired specimens is diagnostic. In the Weil-Felix reaction a single specimen titer of 1:160 or a fourfold rise in paired specimens is confirmatory.

Treatment with either tetracycline or chloramphenicol should be begun immediately in cases which have a history of tick bite followed a few days later by chills, fever and rash. Because of the severity of complications, treatment should be begun as soon as the disease is suspected. Chloromycetin and tetracycline are equally effective, with oral tetracy-

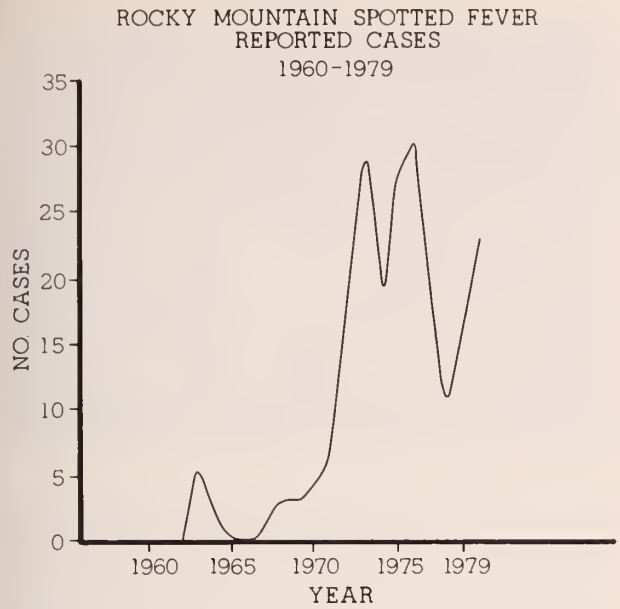


Figure 2. Cases reported in Mississippi, 1960-1979.

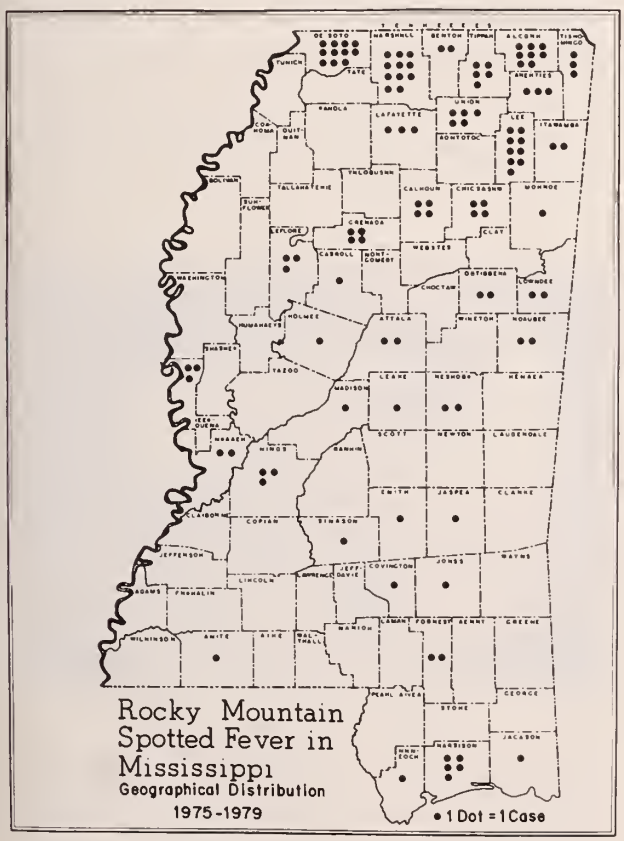


Figure 3. Distribution of reported cases in Mississippi.

cline being used for the milder cases and intravenous chloromycetin recommended for the more severe infections and where meningococcemia is an important consideration in the differential diagnosis.

Summary and Conclusions

1. The reported cases of Rocky Mountain spotted fever have increased in Mississippi over the past ten years.

2. The disease should be suspected and treatment begun where there is history of a tick bite or the handling of dog ticks followed by the abrupt onset of chills, fever, myalgia and headache with subsequent development of a rash occurring within a few days.

3. Two-thirds of the cases in the last five years have occurred in a tier of northeastern and north Mississippi counties, including DeSoto, Marshal, Benton, Tippah, Alcorn, Tishomingo, Tate, LaFayette, Union, Prentiss, Lee, Ittawamba, Pontotoc, Calhoun and Grenda. Physicians in these counties should maintain a high level of suspicion for the occurrence of R.M.S.F. in febrile illness with a maculopapular or purpuric rash. ★★★

2500 North State Street (39216)

References

1. Burgdorfer, W.: A review of R.M.S.F. (tick-borne typhus), its agent and its tick vectors in the U. S. J. Med. Entomology, 12(3):269-278, 1975.
2. Burgdorfer, W., Cooney, J. C. and Thomas, L. A.: Zoonotic potential (Rockey Mountain spotted fever and tularemia) in the Tennessee Valley Region II: Prevalence of rickettsia rickettsii and francisella tularensis in mammals and ticks from land between the lakes. Am. J. Trop. Med. and Hyg., 23(1):109-117, 1974.
3. Cooney, J. C. and Burgdorfer, W.: Zoonotic potential (R.M.S.F. and tularemia) in the Tennessee Valley Region I: Ecologic studies of ticks infesting mammals in land between the lakes. Am. J. Trop. Med. and Hyg., 23(1):99-108, 1974.
4. D'Angela, L. J., Winkler, W. G. and Bregman, D. J.: Rocky Mountain spotted fever in the U. S. 1975-1977. J. Infec. Dis., 138(2):263-276, 1978.
5. Hattwick, M. A., O'Brien, R. J. and Hanson, B. F.: Rocky Mountain spotted fever: Epidemiology of an increasing problem. Ann. Inter. Med., 84(6):732-739, 1976.
6. Keenan, K. P., Buhles, W. C., Jr., Huxsoll, D. L., Williams, R. G., Hildebraudt, P. K., Campbell, J. M. and Stephenson, E. H.: Pathogenesis of infection with rickettsia rickettsii in the dog: A disease model for Rocky Mountain spotted fever. J. Infec. Dis., 135(6):911-917, 1977.
7. Sexton, D. J. and Burgdorfer, W.: Clinical and epidemiological features of R.M.S.F. in Miss. 1933-1973. So. Med. J., 68(2):1529-1535, 1975.
8. Linnemann, C. C., Jr., Jansen, P. and Schiff, G. M.: Rocky Mountain spotted fever in Clermont County, Ohio: Description of an endemic focus. Am. J. Epidem., 97(1):55-64, 1973.
9. Sonenshine, D. E., Peters, A. H. and Levy, G. F.: Rocky Mountain spotted fever in relation to vegetation in the eastern United States, 1951-1971. Am. J. Epidem., 96(1):59-69, 1972.

Radiologic Seminar CCXV: Computed Tomography Evaluation of Adrenal Glands

DOUGLAS E. CLARK, JR., M.D.
Tupelo, Mississippi

WITH THE ADVENT of computerized tomography, we now have an accurate non-invasive method of evaluating patients with suspected adrenal pathology. The procedure is technically easily done and can be done on an outpatient basis. The majority of patients evaluated would be those with clinical or biochemical evidence of Cushing's syndrome, pheochromocytoma, aldosteronoma, or metastatic disease.[1]

The adrenal glands are ideal structures for visualization by computed tomography, since they are generally surrounded by fat in the retroperitoneum. The adrenal glands have a characteristic shape and location on CT. The right adrenal gland generally appears on sections above the right kidney and appears as a linear-shaped structure which extends posteriorly from the inferior vena cava into the retroperitoneal fat between the posteromedial aspect of the right lobe of the liver and the crus of the diaphragm and vertebral body. Occasionally the right adrenal gland will be shaped like an inverted V. The left adrenal gland is generally seen on sections that include the superior pole of the left kidney because the gland lies adjacent to the anterior surface of the superior pole of the left kidney. The left adrenal gland is generally shaped like an inverted V or Y or occasionally as a triangular-shaped density. The left adrenal gland lies lateral to the left crus of the diaphragm and aorta and is posterior to the tail of the pancreas and splenic vessels (see Figure 1).[2, 3]

In patients with clinical or biochemical abnormalities suggesting adrenal pathology, the CT scan may show unilateral or bilateral adrenal enlargement. This finding is non-specific but is helpful in separating those cases where unilateral tumor is present from those cases where adrenal hyperplasia produces the clinical syndrome. The differential diagnosis of unilateral masses in the adrenal gland is fairly large but principally includes adenoma, carcinoma, pheochromocytoma, and metastasis. Patients with bilateral adrenal hyperplasia may have normal size glands or slightly enlarged glands on CT. In patients with hyperplasia the glands generally retain their normal shape. Adjacent structures such as tortuous splenic vessels, portions of the duodenum, and the inferior vena cava may cause some localization problems, but these generally can be resolved with oral and intravenous contrast. The radiation dose from computerized tomography is generally about the same as conventional radiologic procedures such as excretory urography with tomography and is considerably less than the radiation dose from selective abdominal angiography.

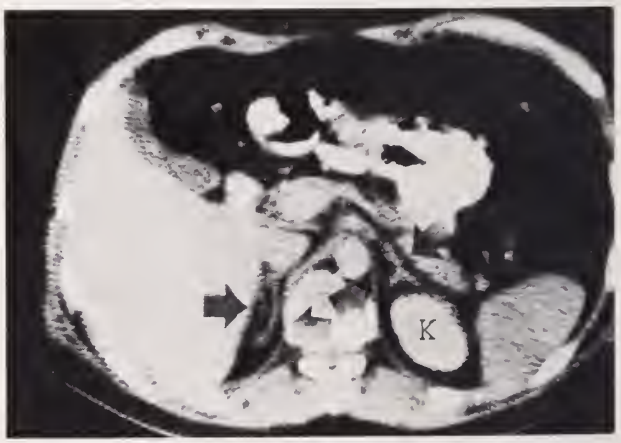


Figure 1. The normal right adrenal gland is a linear density which is seen in the retroperitoneal fat between the medial right lobe of the liver and crus of the diaphragm and spine. The normal left adrenal gland is seen as an inverted Y structure lying anterior to the upper pole of the left kidney (K).

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, North Mississippi Medical Center, Tupelo, MS.



Figure 2. A small tumor is demonstrated in the left adrenal gland between the aorta (A) and the upper pole of the left kidney (K). The normal right adrenal gland is seen as a linear structure in its normal location.



Figure 3. A large mass is shown anterior to the upper pole of the right kidney (K).

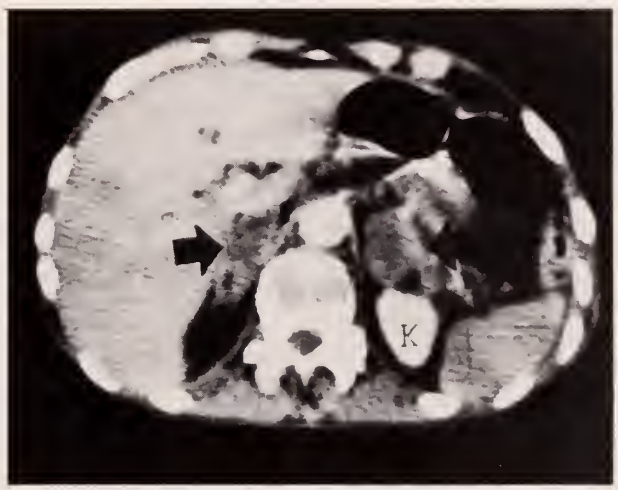


Figure 4. Arrows denote bilaterally enlarged adrenal glands showing mottled density. These adrenal glands were involved with metastatic disease.

Case 1

A 23-year-old female presented with hypertension and episodes of severe weakness and was found to have low serum potassium values. The patient's plasma renin activity was noted to be significantly depressed. The clinician evaluating the patient had a strong suspicion of Conn's syndrome and referred the patient for CT evaluation of the adrenal glands.

CT scanning of the adrenal glands revealed a small low density lesion in the left adrenal gland with a normal appearing right adrenal gland (see Figure 2). The size of the lesion was estimated at 1.5 cm in greatest diameter. Further evaluation of the patient included adrenal venogram and adrenal vein sampling. The patient subsequently underwent surgery, and a small adrenal adenoma measuring 1.3 cm was found in the left adrenal gland. The patient has done well post-operatively with a return of her blood pressure to normal values.

Case 2

A 58-year-old female presented with episodic hypertension with the possibility of a pheochromocytoma being considered in the differential diagnosis. The patient had CT evaluation of the adrenal glands with a relatively large mass demonstrated above the right kidney (see Figure 3). It was somewhat difficult on the CT scan to determine if the mass actually arose from the adrenal or from the right kidney, and the patient did have selective angiography which suggested this was adrenal in origin. The patient subsequently underwent surgery with a 6.5 x 5 cm mass resected which proved to be a pheochromocytoma.

Case 3

A 51-year-old male was presented with a history of metastatic carcinoma of unknown origin. CT scanning was done for evaluation of the pancreas and scans included the adrenal glands, which were noted to be bilaterally enlarged with non-homogenous density. This was interpreted to most likely represent bilateral adrenal metastatic disease (see Figure 4). The patient subsequently expired and autopsy demonstrated bilateral adrenal metastases.

The adrenal glands should be visualized in 90% to 95% of patients by computed tomography. Failure to visualize the adrenal glands is generally due to small amounts of retroperitoneal fat outlining the adrenal

glands.[4] Scans at the North Mississippi Medical Center are done on an Ohio Nuclear 2020 body scanner utilizing 4 mm sections through the adrenal glands. The patients are generally given oral and intravenous contrast to aid in visualizing bowel loops and adjacent vascular structures.

Computerized tomography would seem to be the method of choice for evaluating patients with suspected adrenal pathology. Ultrasound is frequently limited by bowel gas and retroperitoneal fat, and in the evaluation of adrenal pathology the CT scanner seems to be more sensitive in identifying small lesions. Angiography and venography will remain adjunctive procedures in the diagnosis of adrenal disease. ★★★

835 Garfield Street (38801)

References

1. Korobkin, M., White, E. A., Kressel, H. Y., Moss, A. A. and Montagne, J.: Computed tomography in the diagnosis of adrenal disease. Amer. J. Roentgen. 132:231-238, Feb. 1979.
2. Dunnick, N. R., Schaner, E. G., Doppman, J. L., Strott, C. A., Gill, J. R. and Javadpour, N.: Computed tomography in adrenal tumors. Amer. J. Roentgen. 132:43-46, Jan. 1979.
3. Epstein, A. J., Patel, S. K. and Petasnick, J. P.: Computerized tomography of the adrenal gland, JAMA, Vol. 242, No. 25:2791-2794, Dec. 1979.
4. Reynes, C. J., Churchill, R., Moncada, R. and Love, L.: Computed tomography of adrenal glands. Radiol. Clin. N. Amer. Vol. XVII, No. 1:91-104, April 1979.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

July 23-25, 1981
ADVANCED CARDIAC LIFE SUPPORT
Meridian, Mississippi

October 14-17, 1981
FAMILY PRACTICE UPDATE
Jackson, Mississippi

December 10-11, 1981
PERINATAL POSTGRADUATE COURSE
Jackson, Mississippi

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Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemalytic streptococci
Branchitis and pneumonia caused by *S. pneumaniae* (farmerly *D. pneumaniae*)
Otitis media caused by *S. pneumaniae* (formerly *D. pneumaniae*) and *H. influenzae*
Acute exacerbatian of chranic branchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacterialogic cures cannot be expected in all patients with chronic respiratary disease due ta *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Graup A beta-hemalytic streptacacci and staphylacacci, nanpenicillinase producers.
URINARY TRACT INFECTIONS caused by *E. cali* and *P. mirabilis*. (This drug shauld nat be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to manitar effectiveness af therapy and susceptibility of bacteria. Therapy may be instituted priar ta results af sensitivity testing
Contraindications Contraindicated in individuals with histary af an allergic reactian ta penicillins.
Warnings Cyclacillin should only be prescribed far the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious far recammended indications.
Serious and occasional fatal hypersensitivity (anaphylactaid) reactions have been reparted in patients an penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and ather allergens. If allergic reaction occurs, discantinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use af antibiotics may promote avergrowth of nansusceptible organisms. If superinfection accurs, take apprapriate measures.
PREGNANCY: Pregnancy Category B. Repraductian studies perfarmed in mice and rats at dases up ta 10 times the human dose revealed no evidence of impaired fertility ar harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal repraduction studies are nat always predictive of human response, use this drug during pregnancy anly if clearly needed
NURSING MOTHERS: It is nat knawn whether this drug is excreted in human milk. Because many drugs are, exercise cautian when cyclacillin is given to a nursing waman.
Adverse Reactions Oral cyclacillin is generally well talerated. As with other penicillins, untoward sensitivity reactians are likely, particularly in thase who previausly demanstrated penicillin hypersensitivity ar with history af allergy, asthma, hay fever, ar urticaria. Adverse reactians reported with cyclacillin: diarrhea (in appraximately 1 out af 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in appraximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reparted. (See WARNINGS) Other less frequent adverse reactians which may occur and are reparted with other penicillins are anemia, thrambacytapenia, thrambacytopenic purpura, leukopenia, neutrapenia and eosinaphilia. These reactions are usually reversible on discantinuatian af therapy.
As with other semisynthetic penicillins, SGOT elevatians have been reported.
As with antibiatic therapy generally, continue treatment at least 48 to 72 haurs after patient becames asymptomatic ar until bacterial eradicatian is evidenced. In Graup A beta-hemalytic streptacaccal infectians, at least 10 days' treatment is recammended ta guard against risk af rheumatic fever or glamerulanephritis. In chranic urinary tract infectian, frequent bacterialagic and clinical appraisal is necessary during therapy and passibly far several manths after. Persistent infection may require treatment far several weeks.
Cyclacillin is nat indicated in children under 2 manths af age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due ta prolanged serum half-life, patients with variaus degrees af renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced doses)

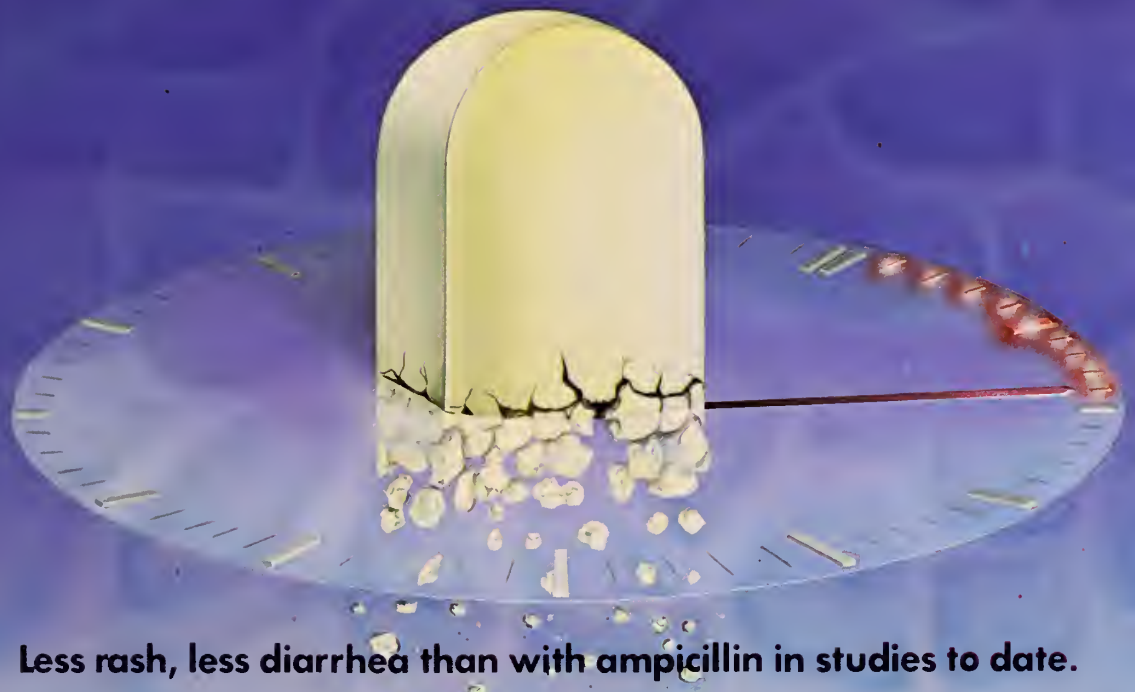
INFECTION	ADULTS	CHILDREN*
Respiratary Tract		
Tansillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d.
		body weight > 20 kg (44 lbs) 250 mg q.i.d
Branchitis and Pneumania		
Mild or Maderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chranic Infections	500 mg q i d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg ta 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg ta 500 mg q.i.d.†	50 ta 100 mg/kg/day†
Urinary Tract	500 mg q i.d.	100 mg/kg/day

*Dosage shauld not result in a dase higher than that for adults.
†depending on severity

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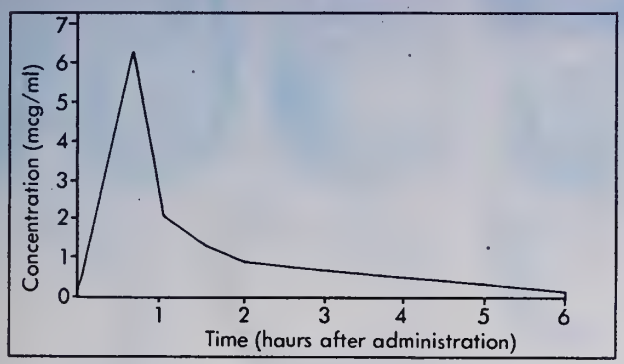
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Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

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Causative Organism	Branchitis/Pneumania†	Na. of Patients
S. pneumaniae	100%	73
	95%	
Chranic Branchitis† (acute exacerbation)		
H. influenzae	92%	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	
Streptacoccal Sare Throat†		
Graup A beta-hemalytic Streptacaccus	100%	44
	86%	
% Clinical Respanse % Bacterial Eradicatian		

†Due ta susceptible organisms.

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State Board of Health Looks at Consolidation of Programs, Possible Reductions

CHARLES L. MATHEWS

PRESIDENT REAGAN has proposed cuts in federal funding for Medicaid, Categorical (Health) Grant Programs, and Health Professions Training Programs. To determine what effect these proposed cuts might have in Mississippi, JOURNAL MSMA recently interviewed Mr. Billy F. Simmons, Director of the Mississippi Medicaid Commission; Dr. Alton B. Cobb, Executive Officer of the Mississippi State Board of Health; and Dr. Norman A. Nelson, Vice-Chancellor and Dean of the University of Mississippi School of Medicine. This issue presents the second in the series of interviews.

Editorial Note: The Reagan Administration is seeking to abolish some 25 federally-funded categorical health programs and to replace them with two block grants to the states. Additionally, current federal expenditures for the programs would be reduced by 25%. There would be a Preventive Health Block Grant and a Basic Health Services Block Grant. Current categorical health programs to be replaced by the former include: child and influenza immunization, hypertension, fluoridation, family planning and venereal disease control. Current categorical health programs replaced by the latter include: community health centers, emergency medical services, community mental health centers, crippled children's services, and maternal and child health. Under the proposed new block grants, the states would be given flexibility to spend federal funds for health promotion and disease prevention activities (Preventive Health Block Grant) or basic health services (Basic Health Services Block Grant), and up to 10% of federal funding in one block could be transferred to the other. States would be prohibited from using the block grants funds for cash payments to intended recipients and for land purchases or building construction as can now be done under some of the categorical grant programs.

JOURNAL MSMA: Dr. Cobb, how do you generally view the Reagan Administration's proposal to consolidate and reduce federal expenditures for some 25 health categorical grant programs?

Second in a series examining effects of federal budget cuts on health care programs in Mississippi.

DR. COBB: Perhaps surprisingly to some, I and the other state and territorial health officers support the concept of consolidating present public health grant programs. A resolution to this effect was passed at our recent national meeting. We are concerned about the mix of consolidation being proposed and the proposed cut of 25%.

JOURNAL MSMA: What are some of the programs being proposed for consolidation?

DR. COBB: At the State Board of Health, some of the programs would be the crippled childrens' program, the emergency medical services program, and the maternal and child care program. Other programs being proposed for consolidation which are administered by other state agencies are the health planning program and the mental health program.



JOURNAL MSMA: You mentioned concern about the mix of consolidation being proposed for some of these programs. What do you mean?

DR. COBB: I would like to see three or maybe four block grants for health instead of the two proposed by the administration with, for example, mental health and maternal and child care being two distinct block grants. I might note that the AMA has suggested that the latter program be a distinct block grant, or that all programs affecting maternal and child health be placed in one block.

JOURNAL MSMA: Why do you recommend separating these particular programs into separate block grants?

DR. COBB: I think that the programs as presently constituted necessarily contain elements of both the proposed block grants (i.e. preventive services and health services) and if separated would erode into one or the other.

JOURNAL MSMA: What would you identify as the advantages of block grants over the present categorical grants?

DR. COBB: The state will have more flexibility to decide how monies will be spent under the block grants. We can address health needs statewide instead of having particular groups targeted for help as under the categorical grants.

JOURNAL MSMA: Let's talk about the proposed 25% reduction. You said you had some concerns?

DR. COBB: Yes! If the reduction comes from savings generated through an end to expensive reporting, record keeping, and federal supervision, that's one thing. If it comes from reducing services, that's something else, and I don't think we should reduce services, particularly here in Mississippi.

JOURNAL MSMA: How much of the State Board of Health's budget is affected by the block grant proposal?



DR. COBB: Of our $66.4 million budget for this fiscal year, some $17 million would be involved in the block grant proposal.

JOURNAL MSMA: There has been some concern expressed nationally about the ability of some states to effectively administer block grants. Health programs in some states, for example, are presently skewed among welfare programs, or there are several different agencies administering the programs with no apparent reference point for development of overall policy. What state agencies in Mississippi are affected by the Reagan Administration's block grant proposals on health?

DR. COBB: The state agencies involved would be the State Board of Health, Department of Mental Health, Mississippi Medicaid Commission and Mississippi Health Care Commission.

JOURNAL MSMA: Are those not all separate and distinct agencies?

DR. COBB: Yes.



The President Speaking

A Goal and a Pledge

R. FASER TRIPLETT
Jackson, Mississippi

I would like to express my sincere appreciation to each of you who through your delegate to the 113th Annual Session of the MSMA elevated me to the highest office of our association, the presidency. I take great pride in being so honored by my fellow physicians, yet I feel a tremendous sense of humility in assuming the awesome responsibilities that this office entails. I feel most fortunate in being chosen from so many capable and able physicians among us, and I am honored to follow the dedicated, selfless men who have preceded me in this office.

As I told the House of Delegates in my words of acceptance, I would like to lead our association this year toward a goal that will result in a greater commitment by all of us to the political process in both time and money.

I would like to quote partially from the preamble to the constitution of the MSMA: "That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor." A concise literal translation of the quote could easily be "quality medical care for our patients." This is and must be our *first priority*.

I think most of us believe that in order to provide such care, we must maintain our private practice system for the delivery of medical care, which is one of the last bastions of the free enterprise system. The course of action should be quite clear to us — greater involvement by physicians in the political process at all levels, beginning in the precinct and ending in Washington. We have the greatest opportunity we have had in years to do so. The climate is ripe and we must take advantage of it.

The first place to start is with MMPAC. This past year only 650 of 1811 member doctors joined MMPAC by making the minimum contribution of $20. It takes money to fight for our cause and we must provide it. MMPAC is the only source of funds we have to make contributions to legislative candidates, and it must be strengthened. A $100 MMPAC Club has been formed, and I invite and strongly urge every member of our society to become a member. When you really consider the importance of our cause and the consequences if we fail, $100 is a mere pittance.

(Continued on page 153)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 6

JUNE 1981

No Doctor Surplus In Small Communities

With the sophisticated tools, laboratory aids, and radiographics at the disposal of today's practitioner, more and more of his time is required per patient. Third party payment covering the vast majority of people today further increases the utilization of the physician's time.

Well care, relatively rare a few decades ago, requires an increasing percentage of the physician's time. So it is obvious that more doctors are required per unit of population than ever before.

Medical manpower continues to be a subject of discussion and concern. Only a few years ago HEW insisted on the expansion of medical schools, and increased their subsidy to increase the number of physicians. Later, as a result of this, a glut of doctors was anticipated, and it was thought feasible to decrease the number of MDs being graduated. Whether the excess is real or imagined, the number of doctors serving small communities and outlying areas is decreasing.

Just as the need for primary care physicians was realized with the near demise of the general practitioner and schools were finally persuaded to encourage and train family practitioners, perhaps we must now consider the need for and encouragement of office based practitioners. If this can be achieved, our distribution of physicians will much more nearly meet the needs of society.

W. Moncure Dabney, M.D.
Editor

THE PRESIDENT SPEAKING

(Continued from page 152)

We must all get involved in our local elections — donating time, money, and effort to those who are philosophically in tune with us. I sincerely believe that unless we dedicate ourselves to more active involvement along these lines, we eventually will see our present fee-for-service system for the delivery of medical care eroded to the extent that our ability to practice quality medical care will be seriously impaired.

Thank you for your confidence and trust. I may not accomplish all my goals this year, but I pledge to you 100% of the time and effort it requires to see that our association is properly represented, that our heritage is protected, that our standards are maintained, and our priority to provide quality medical care is strengthened. And most of all, I personally and sincerely pledge to you my loyalty to our association and to our profession. I look forward to visiting each of you during the year.

Thank you again and God bless you.

The Mississippi State Medical Association is grateful to the following companies for their financial support of the 113th Annual Session:

Blue Cross-Blue Shield of Mississippi, Inc.
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PERSONALS

Thomas Blake of UMC attended a recent meeting of the Board of Governors of the American College of Physicians in Kansas City.

Frank W. Bowen of Carthage was named "Man of the Year" by the Leake County Chamber of Commerce.

Wallace Conerly of UMC participated in a board of directors meeting of the Tri-State Respiratory Therapy Conference in Biloxi.

John R. Ford has associated with The Street Clinic in Vicksburg for the practice of family medicine.

Alan E. Freeland of UMC presented a paper at the recent annual meeting of the American Society for Surgery of the Hand in Las Vegas.

Frank Gruich of Biloxi was inducted into the Sacred Heart-Notre Dame Alumni Association and Friends Hall of Fame.

Larry Hammett of Hattiesburg spoke at a meeting of the newly formed Southwest Mississippi Chapter of the Juvenile Diabetic Foundation.

James Hardy of UMC was invited lecturer at the Field Memorial Community Hospital in Centreville in March.

John S. Harris of Meridian has been certified by the American Board of Obstetrics and Gynecology.

Herbert Langford of UMC was a program participant at the 21st Annual Conference on Cardiovascular Disease Epidemiology in Washington, DC.

John D. McRae, Jr. of Laurel announces the opening of his new office for the practice of general surgery at 608 Second Avenue.

Benjamin P. Monaco of Pascagoula announces the association of Alan J. Clark for the practice of ophthalmology.

John Morrison of UMC was visiting professor at Methodist Hospital in Indianapolis, IN.

Larry Smith of Hattiesburg conducted a seminar on hematology at Forrest General Hospital.

Robert R. Smith of UMC moderated a panel discussion during the recent meeting of the American Association of Neurological Surgeons in Boston.

James P. Spell of Jackson was featured speaker at the Omicron Delta Kappa spring lecture at Mississippi College.

Dan R. Thornton, Jr., of Meridian was one of five fellows in the American College of Obstetrics and Gynecology to receive the "Outstanding District Service Recognition" during the College's recent convocation.

Robert J. Trautman, Jr., announces the opening of his office for the practice of dermatology at 2200 South Lamar in Oxford.

John D. Wilson of Columbus announces the relocation of his office for the practice of neurosurgery to 2461 Fifth Street, North.

NEW MEMBERS

Byrne, David Edward, Gulfport. Born New Orleans, LA, June 30, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and general surgery residency, University Medical Center, Jackson, 1975-1980; elected by Coast Counties Medical Society.

Jirsa, Harold Otto, Ocean Springs. Born Cedar Rapids, IA, June 4, 1911; M.D., University of Iowa College of Medicine, Iowa City, 1935; interned Akron City Hospital, Akron, OH, one year; surgery residency, University of Pennsylvania, Philadelphia, 1936-37; surgery residency, Akron City Hospital, 1937-39; surgery residency, University of Iowa, Iowa City, 1945-47; elected by Singing River Medical Society.

Kanade, Ashok. Born India, July 5, 1945; M.D., Osmania Medical College, Hyderabad, India, 1970; interned Christ Community Hospital, Oak Lawn, IL, one year; internal medicine residency, V. A. Hospital, New Orleans, 1973-75; cardiology residency, same, Jan. 1976-June 1978; elected by Coast Counties Medical Society.

Vinson, Thomas Lynn, Columbus. Born Oxford, MS, Sept. 1, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1945; interned and general surgery residency, University of South Alabama, Mobile, 1975-80; elected by Prairie Medical Society.

Dr. R. Faser Triplett Is Inaugurated President, Dr. Sidney O. Graves Is Named President-Elect

Delegates to the 113th Annual Session elected Dr. Sidney O. Graves of Natchez as president-elect of the association. Dr. R. Faser Triplett of Jackson was inaugurated 1981-82 president, succeeding Dr. Paul H. Moore of Pascagoula. The elections capped a heavy House of Delegates agenda which included some 30 reports and resolutions and presentation of awards.

In other elections, Drs. John M. Estess of Hollandale, Walter D. Gunn of Quitman, and Victor E. Landry of Lucedale were named vice presidents. Dr. Carl G. Evers of Jackson was re-elected speaker of the House of Delegates, and Dr. James C. Waites of Laurel was named vice speaker. Dr. Myron W. Lockey of Jackson was re-elected associate editor.

Dr. James O. Gilmore of Oxford was named to another term as delegate to the AMA, and Dr. Stanley A. Hill of Corinth was re-elected alternate delegate.

Named to the Board of Trustees were Drs. James O. Manning of Jackson, W. Boyce White of Laurel, David R. Steckler of Natchez, and Roy D. Duncan of Pascagoula.

Delegates elected Dr. Sam B. Johnson of Jackson and Dr. C. D. Taylor of Pass Christian to posts on the Council on Budget and Finance, and Dr. Frederick E. Tatum to another term on the Council on Constitution and Bylaws.

Elected to other council posts were: Drs. Robert L. Coggin of Grenada, Fred McMillan of Jackson and William M. Gillespie of Meridian — Judicial Council; Drs. Robert S. Cooke, Jr., of Hattiesburg, H. Vann Craig of Natchez and Dewey H. Lane of Pascagoula — Council on Legislation; Drs. Mack Gorton of Belzoni, Horton G. Taylor, Jr., of Ripley and J. M. Patterson of Pontotoc — Council on Medical Education; and Drs. Virginia S. Tolbert of Parchman, David A. Ball of Batesville, and Thomas S. Parvin of Starkville — Council on Medical Service.



Dr. R. Faser Triplett of Jackson was inaugurated president of the association during the 113th Annual Session. With him are Dr. Sidney O. Graves of Natchez, at left, 1981-82 president-elect, and Dr. Paul H. Moore of Pascagoula, immediate past president.



Dr. Sidney Graves, left, administers the oath of office to Dr. Faser Triplett, assisted by MSMA Executive Secretary Charles Mathews, center.

113th Annual Session Had Full Schedule of Activities

More than 600 physicians, spouses and guests attended the 113th Annual Session held last month at the Biloxi Hilton. This number included MSMA and Auxiliary members, exhibitors, guests, students, interns, residents, and MSMA staff. Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly, reported that approximately the same number of MSMA members attended last year's annual meeting.

A faculty of 40 medical speakers from 11 states presented papers during meetings of 14 scientific sections and meetings of 15 medical specialty groups. The scientific program included the First Annual James Grant Thompson Memorial Lecture, featuring Dr. Gerald Weissmann of New York University School of Medicine as lecturer. His topic was "Prostaglandins in Acute Inflammation."

Specialty societies meeting on Sunday included the Mississippi EENT Association, Mississippi Dermatology Society, Mississippi Association of Pathologists, Academy of Facial Plastic and Reconstructive Surgery, Mississippi Psychiatric Association, and Mississippi Orthopedic Society.

Monday's schedule included meetings of the Mississippi Society of Plastic and Reconstructive Surgery and the Mississippi Gastrointestinal Society. Specialty groups meeting on Tuesday were the Mississippi Chapter of the American College of Surgeons, Mississippi Society of Internal Medicine, and the Mississippi Urological Society. Meeting on Wednesday were the Mississippi Ob-Gyn Society, the Mississippi Chapter of the American Academy of Pediatrics, the Mississippi Perinatal Association and the Mississippi Academy of Family Physicians.

The Mississippi Medical Fraternal and Educational Society held its fifth annual membership meeting on Sunday, April 26, with Mrs. Betty Britton, patient advocate at the Mississippi Baptist Medical Center, as guest speaker.

Senator Thad Cochran was guest speaker for the annual meeting of the Mississippi Foundation for Medical Care, which was held on Monday.

Also conducting meetings during the five-day session were the Association of American Physicians and Surgeons, Flying Physicians Association, the MSMA Past Presidents and Fifty Year clubs, and medical alumni from Tulane, LSU, Tennessee and Ole Miss.

A record number of entrants was reported for the annual MSMA tennis and golf tournaments, and enthusiasm was high for two new activities introduced at this year's annual session — a two-day fishing rodeo and an art exhibit featuring works by MSMA members and spouses.

The MSMA Auxiliary conducted its 58th Annual Session, with a full schedule of business meetings and special activities.



Dr. Carl Evers of Jackson presided as speaker of the House of Delegates.



Dr. Paul Moore receives the Past President's Pin from Mrs. James Grant Thompson.



Dr. W. Lamar Weems of Jackson received the 1981 MSMA-Robins Award for Community Service. The citation recognized Dr. Weems' outstanding contributions to improving the education of the deaf citizens of Mississippi.



Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly, announces attendance figures during one of the House sessions.



Mrs. John Estess, 1981-82 Auxiliary president, addressed the Thursday session of the House.



Dr. Norman A. Nelson, right, dean of the University of Mississippi School of Medicine, accepts a check for $22,857.22 from Dr. Moore and Mrs. Ted Blanton, AMA-ERF chairman for the MSMA Auxiliary.



Student delegates Ben Folk, Jr. and Don Marascalco and UMC resident delegate Dr. Steven Haynes arrive for the House session.





Members of the reference committees discussed their responsibilities during a breakfast meeting.





Members of the House of Delegates receive copies of reports and resolutions as they arrive for the House session.



Delegates prepare to mark ballots.

113th Annual Session, April 26-30, 1981

HOUSE OF DELEGATES HANDLES BUSY AGENDA

The House of Delegates of the Mississippi State Medical Association handled a busy agenda of reports and resolutions at the recent 113th Annual Session of the association in Biloxi. The official transactions of the meeting will be mailed to all delegates.

The MSMA House of Delegates took these major actions:

- Directed that representatives of the association meet with the state's Congressional delegation and other appropriate officials to seek equity in Medicare fees paid on behalf of patients in Mississippi.

- Urged that a committee composed of concerned governmental and professional representatives be appointed to study the financial status of the Mississippi Medicaid Program and the effects of purchasing each eligible beneficiary a health insurance plan and administering the nursing home program as a separate program.

- Support registration under the Board of Medical Licensure of all allied health occupations presently unlicensed in the state.

- Seek legislative enactment of the AMA model bill establishing standards for multiphasic health screening units.

- Seek standardization of claims procedures of third party payors in Mississippi to include procedural terminology, definition of outpatient benefits, definition of usual, customary and reasonable charges, and definitions of medical and surgical coverage.

- Directed the Board of Trustees to study the present composition and future structure of the MSMA Scientific Section.

- Changed the annual session to a June, Thursday through Sunday, meeting format beginning in 1983 or as soon thereafter as meeting space can be obtained.

- Went on record in support of a strong campaign to eliminate drivers under the influence of alcohol from the roads and highways of the state.

- Urged fair market competition for HMOs and the elimination of government subsidies and support for HMOs.

- Urged elimination of all government direction of peer review.

- Established annual leadership conference for officers of the association, component societies and specialty societies.

- Established a committee composed of the past presidents of the association to commemorate the 125th Anniversary of the association, which will occur December 15, 1981.

- Urged support of the MSMA Jail Project by local Boards of Supervisors.

- Commended the MSMA Disabled Doctors' Program and urged voluntary contributions to support the program.

- Urged support of the American College of Surgeons' and American Cancer Society's hospital-based cancer education and control programs.

- Established a program to assist component societies of the association with local media programs.

- Endorsed legislation to provide complete confidentiality of peer review proceedings.

- Endorsed amendments to the MSMA Constitution and Bylaws to provide that members of the State Board of Medical Licensure and the State Health Officer be members of the House of Delegates.

- Presented 1981 MSMA-Robins Award for Community Service to Dr. W. Lamar Weems of Jackson.

- Presented $22,857.22 to the University of Mississippi School of Medicine representing 1980 AMA-ERF contributions to the school from Mississippi physicians, alumni and their spouses.

The Reference Committee on Credentials reported seating 107 delegates at the opening session of the House of Delegates on April 27 and 111 delegates at the closing session on Thursday, April 30.

Serving on reference committees of the House were:

Reference Committee on Rules and Order of Business

Stanley A. Hill, M.D., Chairman
Katherine A. Pyron, M.D.
J. Edward Hill, M.D.

Reference Committee on Constitution and Bylaws

Mary J. Ward, M.D., Chairman
Frederick E. Tatum, M.D.
George D. Purvis, Jr., M.D.

Credentials Committee

J. Elmer Nix, M.D. Chairman
Robert C. Lee, M.D.
Thomas R. Singley, M.D.

Reference Committee on Reports or Officers, Board of Trustees and Councils

Curtis D. Roberts, M.D., Chairman
David R. Steckler, M.D.
Charles R. Jenkins, M.D.
Stacy Davidson, M.D.
A. A. Derrick, M.D.

Nominating Committee

C. D. Taylor, M.D., Chairman
J. Edward Hill, M.D.
James A. Bruce, Jr., M.D.
Richard Russell, M.D.
Ed Pennington, M.D.
David Scruggs, M.D.
Stan Wade, M.D.
Gerald Gable, M.D.
Moncure Dabney, M.D.

Dr. R. Faser Triplett of Jackson is MSMA's 1981-82 president; Dr. Sidney O. Graves of Natchez was elected president-elect.

114th Annual Session, May 2-6, 1982, at Biloxi — Mark Your Calendar Now for the 125th Anniversary Meeting of MSMA!

Medical and Political Leaders Speak at Annual Session Meetings

Dr. Paul Moore delivered his presidential address to the House of Delegates on Monday, April 27. He stressed the importance of increased membership and increased political involvement, and remarked on the accomplishments of organized medicine. The July issue of JOURNAL MSMA will have the complete text of his address.

Also in the rostrum spotlight was Dr. Robert B. Hunter, president of the AMA. He outlined for delegates the workings of the AMA and described a study the national association had undertaken for the purpose of making long-range plans.

Political leaders, including U. S. Senator Thad Cochran and Congressman Trent Lott, were special guests during the five-day session. Cochran addressed the Monday afternoon meeting of the Mississippi Foundation for Medical Care. MSMA members, spouses and guests enjoyed informal conversations with Congressman Lott and his wife, who attended the President's Reception as guests of Dr. and Mrs. Moore.



Congressman and Mrs. Trent Lott, back row, were special guests of Dr. and Mrs. Paul Moore, front row left, at the President's Reception. At right are Dr. and Mrs. Joe Burnett of Oxford.



U. S. Senator Thad Cochran discussed Washington's view of health care issues during his address at the annual meeting of the Mississippi Foundation for Medical Care.



Dr. Moore responds to a reporter's questions during an interview which was broadcast on WLOX-TV.



Dr. Rod Jenkins of Laurel, left, comments to Dr. Hunter following the AMA president's address to the House of Delegates.

When painful spasm is the presenting symptom...



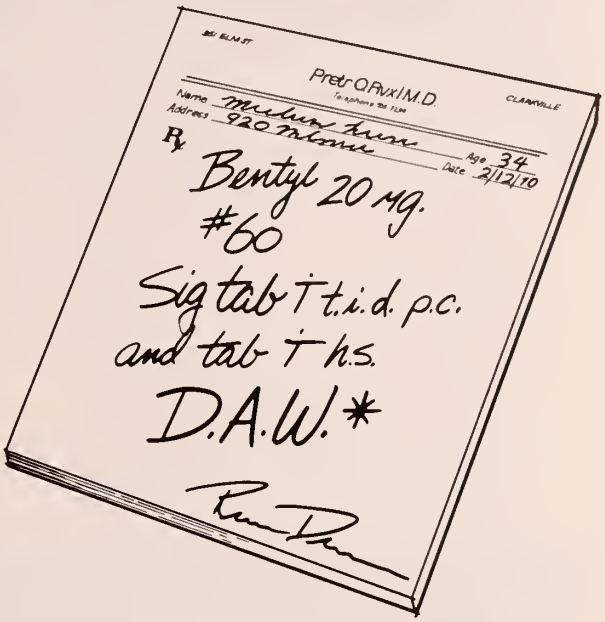
...in the functional bowel/irritable bowel syndrome†

be sure to specify

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



*D.A.W.-Dispense as written

because:

Bentyl passes these tests for product integrity.

- The Bentyl molecule is a product of original Merrell research.
- At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- Bentyl bioavailability of tablets, capsules, syrup and injectable.
- The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- Pharmacologic effect in the distal colon compared to placebo†† shows how Bentyl affects abnormal motor activity in the irritable colon patient.†

† This drug has been classified "probably" effective for this indication.

Merrell

†† In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea, vomiting, impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for
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Dr. Sidney O. Graves, center, chairman of the MSMA Board of Trustees, hosted a luncheon in honor of members of MSMA's Fifty Year Club. From left are Dr. T. J. Barkley of Belzoni, Dr. Omar Simmons of Newton, Dr. Lawrence W. Long of Jackson, and Barbara Shelton, MSMA membership director and club secretary.

Council on Scientific Assembly Begins Planning for 1982

The 1982 annual session is set for May 2-6 in Biloxi, according to Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly. This summer the Council will meet to review preliminary plans and begin work on the program for the 114th Annual Session.

Acting by separate sections during the recent annual meeting, the 14 components of the Council on Scientific Assembly named new chairmen, and eight sections elected new secretaries. Under the bylaws of the association, a section chairman serves a term of one year, but section secretaries are elected for three years to provide continuity. Secretaries of the sections are elected on staggered terms.

Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each scientific specialty.

Dr. Orin F. Guidry of Jackson was elected to chair the Section on Anesthesiology, and Dr. Betty M. Bailey of Gulfport was elected secretary.

Members of the Section on Dermatology named Dr. Donald F. Barraza of Natchez to the chairmanship and Dr. Joseph H. Robinson of Jackson as secretary.

Elected to head the Section on EENT was Dr. James A. Bruce, Jr., of Oxford. Dr. W. Joe Burnett of Oxford enters the third year of his term as secretary.

Dr. D. Stanley Hartness of Kosciusko was named chairman of the Section on Family Practice. Dr. W. K. Stewart continues his term as secretary.

Chairman of the Section on Medicine is Dr. Barry

W. Holcomb of Vicksburg. Dr. Don Q. Mitchell is secretary.

Dr. Thomas R. Singley of Pascagoula was elected chairman of the Section on Ob-Gyn, and Dr. E. J. Price, Jr., of McComb was elected secretary.

Dr. George W. Truett of Jackson will serve as chairman of the Section on Orthopedic Surgery, and Dr. Thomas H. Blake, Jr., of Laurel begins a three-year term as secretary.

Pathologists chose Dr. David R. Steckler of Natchez as chairman and Dr. Philip Saccoccia, Jr., of Gulfport as secretary of the Section on Pathology.

Dr. Frank W. Wilburn of Tupelo was elected chairman of the Section on Pediatrics. Dr. William B. Simmons continues his term as secretary.

Dr. Mary Alice Lee of Jackson and Dr. Alfio Rausa of Greenwood were elected to the posts of chairman and secretary of the Section on Preventive Medicine.

Heading the Section on Surgery is Dr. C. Foster Lowe of McComb. Dr. Jerry Adkins of Biloxi enters the third year of his term as secretary.

Members of the Section on Psychiatry re-elected Dr. William M. Wood of Gulfport as chairman, and elected Dr. Nan Brantley of Jackson as secretary.

Dr. Frank L. Schmidt of Pass Christian was elected chairman of the Section on Radiology, and Dr. Sandra A. Rhoden of Jackson was re-elected secretary.

Dr. Robert F. Carter of Biloxi was named to the post of chairman of the Section on Urology, and Dr. Ronald L. Brown of Gulfport was re-elected secretary.

Ex officio members of the Council on Scientific Assembly are the association president, Dr. R. Faser Triplett of Jackson and the president-elect, Dr. Sidney Graves of Natchez.



Dr. Curtis Roberts of Brandon, left, chairman of the Reference Committee on Reports of Officers, Board of Trustees and Councils, presided at the reference committee hearing. With him are committee members Dr. David Steckler of Natchez, center, and Dr. Stacy Davidson of Cleveland.



Delegates from District 1 met for a caucus during a break in House of Delegates proceedings.



Past presidents of the association attended a breakfast in their honor. Above, left to right, are Dr. Paul Moore of Pascagoula, Dr. Arthur Derrick of Durant, Dr. James O. Gilmore of Oxford, Dr. Guy Vise of Meridian, Dr. Stanley Hill of Corinth, and Dr. Gerald Gable of Hattiesburg.



Among those attending the past presidents' breakfast were, from left, Dr. Lawrence Long of Jackson, Dr. Omar Simmons of Newton, Dr. Lyne Gamble of Greenville, Dr. J. T. Davis of Corinth, Dr. James Royals of Jackson, Dr. Joe Rogers of Biloxi, and Dr. Everett Crawford of Tylertown.



The nominating committee held an open meeting to hear suggestions from members. From right are Dr. Ed Hill of Hollandale, Dr. Gerald P. Gable of Hattiesburg, Dr. C. D. Taylor of Pass Christian, Dr. David Scruggs of Jackson, and Dr. Moncure Dabney of Crystal Springs.



Dr. Roy D. Duncan of Pascagoula, left, and Dr. David Steckler of Natchez, right, were elected to the Board of Trustees.



Delegates re-elected Dr. Carl Evers of Jackson, left, as speaker of the House of Delegates. Dr. James Waites of Laurel, right, was elected vice speaker.

Board of Trustees Names New Officers

There is a new name on the roster of MSMA trustees. Delegates to the 113th Annual Session elected Dr. David Steckler of Natchez to represent District 8. Dr. Roy D. Duncan of Pascagoula, appointed last year to fill Dr. Paul Moore's unexpired term, was elected to a full term representing District 9. In other elections, delegates re-elected Drs. James O. Manning of Jackson and W. Boyce White of Laurel to Board positions.

Dr. Whitman B. Johnson, Jr., of Clarksdale was named chairman of the Board, and Dr. Ellis Moffitt of Jackson was named vice-chairman. Dr. Boyce White will serve as secretary of the MSMA Board of Trustees.

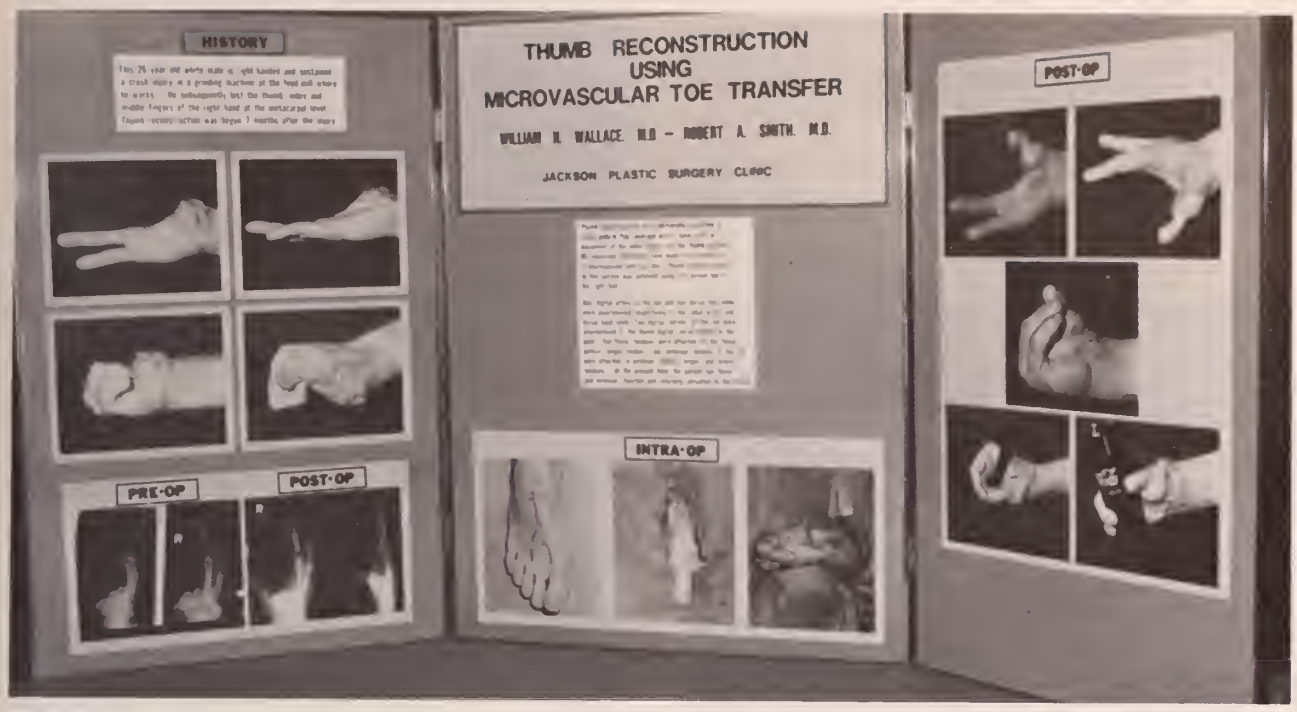
Continuing to serve on the Board are Dr. W. Joe Burnett of Oxford, Dr. William C. Gates of Columbus, Dr. William B. Hunt of Grenada, and Dr. George L. Arrington, Jr., of Meridian.

Six general officers meet with the Board: president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker, and the two AMA delegates.

114th Annual Session

May 2-6, 1982
Biloxi Hilton

Mark your calendars now, and plan to be there for the big 125th anniversary celebration!





Above, "Thumb Reconstruction Using Microvascular Toe Transfer," by Drs. William Wallace and Robert A. Smith of Jackson, received the first place Aesculapius Award. Second place award for excellence of scientific presentation went to Drs. Thomas F. Hewes, William C. Hopper and William L. Seidensticker of Gulfport, for "Athletic Injury of the Lower Extremity."

At left, Dr. Gerald Weissman, professor of medicine and director, Division of Rheumatology at New York University Medical Center, delivered the first James Grant Thompson Memorial Lecture.

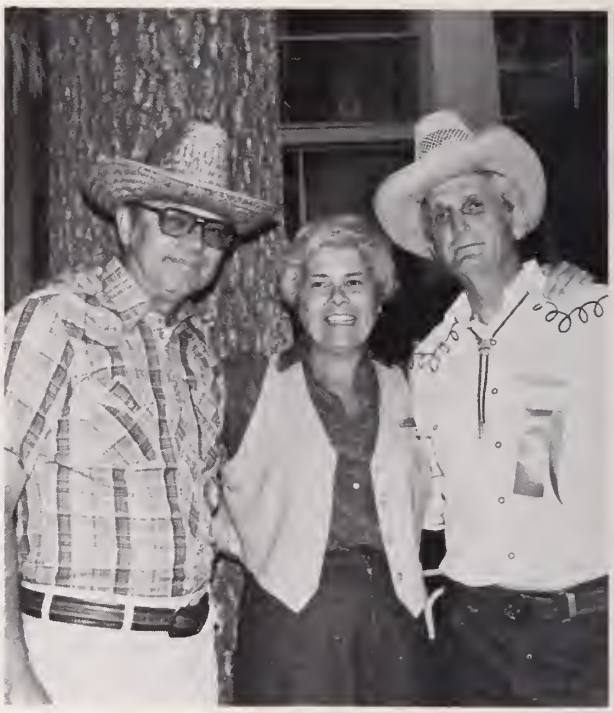


House of Delegates in session.

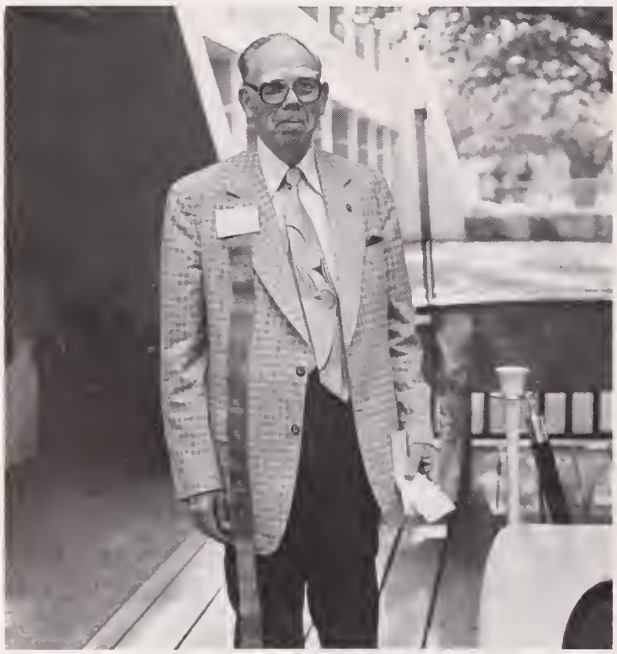
Annual Fellowship Party



Western attire was in evidence at the annual fellowship party which this year featured a country music band and western-style hors d'oeuvres. Dr. George Arrington of Meridian, center foreground, talks with Dr. Sidney Graves of Natchez and Dr. Gerald Gable of Hattiesburg.



MSMA Executive Secretary Charles Mathews, left, and Dr. and Mrs. Paul Moore were among those enjoying the Western party.



Dr. Stanley Hill of Corinth displays his special badge presented to him by the MSMA staff.



The photographer caught Dr. Joe Burnett as he arrived for the Western party.



Dr. Moncure Dabney of Crystal Springs talks with Dan Finch of the AMA's Office of Medical Society Relations.



This Natchez group did a bit of campaigning for their favorite candidate during the Western party, and Dr. Stanley Hill of Corinth, second from left, joined in. From left are Dr. James Funderburg, Dr. David Steckler and Mrs. Sidney Graves.



Mrs. James Grant Thompson of Jackson shows Dr. Moore her trophy for catching the largest Spanish mackeral in the fishing rodeo.

Art Exhibit, Sports Events Highlight Annual Session

MSMA's annual tennis and golf tournaments, a two-day fishing rodeo and an art exhibit generated a great deal of interest during the recent 113th Annual Session as MSMA members, spouses and guests signed up in record numbers for the special activities.

The art exhibit, open each day during the session, featured works by MSMA members and spouses. Mrs. Judi Betts of Baton Rouge judged the entries. According to Mrs. James O. Manning, who coordinated the exhibit, winners were: Mrs. Richard Johnson of Jackson, first place; Mrs. Al Meena of Jackson, second; and Mrs. George Sturgis of Jackson, third. Dr. Jim Hendrick of Jackson received the Judge's Award. Honorable mention went to Mrs. David Duggar of Ocean Springs, Mrs. Walter Colbert of Natchez, Mrs. James O. Manning of Jackson, and Drs. William McKell, Robert Thompson and Ted Blanton, all of Jackson.

More than 200 lbs. of mackeral and red fish were caught during the two-day fishing rodeo, and participants expressed hope that the rodeo would become an annual event. Winners were: Dr. John V. Gwin of

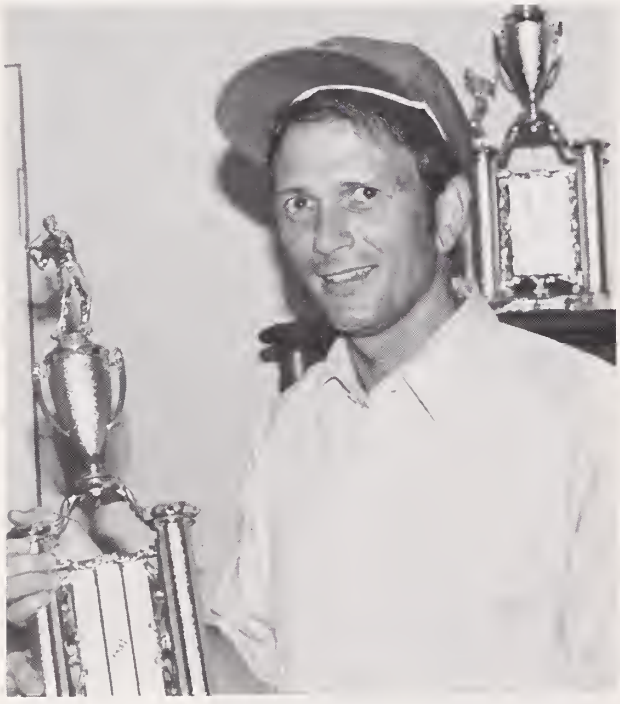


Bucky Murphy of the MSMA staff presents a trophy to Dr. Robert DeCoux of McComb, left, at the golf tournament awards party.

Hattiesburg, largest jackfish; Mrs. James Grant Thompson of Jackson, largest Spanish mackeral; Lewis Lipscomb, Jr., of Jackson (age 9) largest king mackeral; and Dr. Shelton Jackson of Denton, TX, largest bonito.

Dr. James O. Manning of Jackson, chairman of the annual tennis tournament, announced that Drs. William L. Seidensticker and David Sawyer, both of Gulfport, won the men's doubles championship. Receiving the runner-up trophy were Drs. Bruce M. Kuehnle and William E. Godfrey, II, both of Natchez. Men's doubles consolation winners were Drs. William C. Gates of Columbus and Francis S. Morrison of Jackson. Runners-up were Drs. James O. Manning and James C. Hays, both of Jackson. Mrs. Thomas S. Parvin of Starkville and Mrs. William Clement of Gulfport were the women's doubles champions, with Mrs. Wayne Cockrell of Gautier and Mrs. Paul H. Moore, Jr., of Pascagoula, runners-up.

Dr. Tom Garrott of Biloxi received two awards in the golf tournament — first place (low gross) and closest-to-the-pin. Dr. Robert DeCoux of McComb won trophies for second place (low gross) and first place (low net). Dr. George Arrington of Meridian was second place (low net) winner, and Kim McDonald, third year medical student from Quitman, won the award for the longest drive. The golf tournament was held at the Broadwater Sea Course.



Dr. Tom Garrott of Biloxi displays his trophy following the golf tournament awards presentation.



More than 200 lbs. of red fish and mackeral were caught during the two-day fishing rodeo. Above, Dr. Shelton Jackson of Denton, TX, shows off his winning bonito. Below, Dr. S. Jay McDuffie of Nettleton displays a few of the red fish.





An exhibit of art works by MSMA members and spouses was open during the five-day annual session.



Dr. Orin F. Guidry of Jackson, right, was elected chairman of the Section on Anesthesiology. Dr. Betty M. Bailey of Biloxi was named secretary.



Officers of the Section on Psychiatry are Dr. Nan Brantley of Jackson, secretary, and Dr. William Wood of Gulfport, chairman.



Dr. Fred Ingram of Jackson, at right, is the new president of the Mississippi Ob-Gyn Society. With him are, from left, Dr. Earl Stubblefield of Jackson, vice president, and Dr. Glenn Wegener of Clarksdale, president-elect.



Dr. Heber C. Ethridge of Jackson, center front, is president of the Mississippi Society of Plastic and Reconstructive Surgery. Next to him are Dr. Robert Love of Greenville, left, secretary-treasurer, and Dr. Michael E. Jabaley, vice president. Standing, left to right, are Drs. William Wallace, Somprasong Songcharoen and Robert Allen Smith, all of Jackson, and Dr. J. Berlyn Edwards of Biloxi.



Dr. A. C. Jackson, Jr., of Jackson, at left, is president-elect of the Mississippi Urological Society. Dr. Ronald L. Brown of Gulfport, right, is secretary of the society and the MSMA Section on Urology.



Dr. George Truett of Jackson, left, was elected chairman of the Section on Orthopedic Surgery, and Dr. Tom Blake of Laurel, right, was named secretary.



Dr. Frank Schmidt of Pass Christian, left, was elected chairman of the Section on Radiology, and Dr. Sandra Rhoden of Jackson, right, was re-elected secretary.



New officers of the Section on Ob-Gyn are, from left, Dr. E. J. Price, Jr., of McComb, secretary, and Dr. Thomas R. Singley of Pascagoula, chairman.



Auxiliary past presidents who attended a breakfast in their honor are, seated, left to right: Mrs. Sam Rowlett of Vicksburg; Mrs. Jim Barnett of Brookhaven; Mrs. S. B. McIlwain of Pascagoula; Mrs. Ed Hill of Hollandale; and Mrs. J. Gordon Dees of Jackson. Standing, left to right, are: Mrs. Stanley Hill of Corinth; Mrs. Curtis Caine of Jackson; Mrs. Joseph B. Rogers of Biloxi; Mrs. T. E. Ross of Hattiesburg; Mrs. A. T. Tatum of Harriesburg; Mrs. William H. Preston, Jr., of Booneville; and Mrs. S. Lamar Bailey of Kosciusko.

MSMA Auxiliary Conducts 58th Annual Session

The general meeting of the Mississippi State Medical Association Auxiliary's 58th Annual Session took place on Tuesday, April 28, at the Biloxi Hilton. Mrs. John Estess of Hollandale was installed as president, succeeding Mrs. Curtis Roberts of Brandon. Mrs. James Martin of Ocean Springs was named president-elect.

Other officers for 1980-81 include: Mrs. Stanley Hartness of Kosciusko, first vice president; Mrs. James Cooper of Tupelo, second vice president; Mrs. Ben Martin of Columbus, third vice president; Mrs. Louis A. Rubenstein of Ocean Springs, fourth vice president; Mrs. Ed Egger of Greenville, recording secretary; Mrs. Joe Herrington of Natchez, treasurer; Mrs. Sidney Prosser of Hollandale, corresponding secretary; and Mrs. A. T. Tatum of Hattiesburg, parliamentarian.

Special guests attending the auxiliary meeting were Mrs. John G. Bates, first vice president of the AMA Auxiliary, and Mrs. Charles A. Prater, president of Southern Medical Auxiliary.



Mrs. John Estess of Hollandale, seated at right, was installed as 1981-82 president of the MSMA Auxiliary. Mrs. James Martin of Ocean Springs, seated at left, is president-elect. Other officers are, from left, Mrs. Louis A. Rubenstein of Ocean Springs, fourth vice president; Mrs. Stanley Hartness of Kosciusko, first vice president; Mrs. Joe Herrington of Natchez, treasurer; and Mrs. Ben Martin of Columbus, third vice president.



Dr. Barry W. Holcomb of Vicksburg, above, was elected chairman of the Section on Medicine. Dr. Don Q. Mitchell of Jackson is section secretary.



Dr. Whitman B. Johnson, Jr., of Clarksdale, left, is the new president of the American College of Surgeons, Mississippi Chapter. With him is Dr. Jerry Adkins of Biloxi, secretary of the chapter and secretary of the MSMA Section on Surgery.

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FAMILY PHYSICIANS desperately needed to locate in West Central Alabama rural communities, one hour from Birmingham. Faculty appointment with Family Practice Center at University of Alabama if qualified. Join established practice or work individually. Salary of $42,000 to $55,000 guaranteed until practice is self-sufficient. Generous fringe benefits include life, disability, health, retirement, and malpractice insurance, two weeks continuing education, and three weeks annual leave. All equipment, including x-rays and lab, furniture, and supplies provided. Management services including personnel, payroll, tax reports, and billing provided. If invited to visit, all expenses will be paid. All moving expenses covered. Write Health Development Corporation, P.O. Box 1486, Tuscaloosa, AL 35403, or telephone Frank Cochran collect at 758-7545 for more information.

OBSTETRICIAN-GYNECOLOGIST to join 15-member multispecialty group, associated with JCAH-approved hospital. Associate partner status first year with guarantee plus percentage. No investment. Contact Karl Hatten, M.D., or H. Dean Andrews, Administrator, Vicksburg Clinic, Vicksburg, MS 39180.

ORTHOPEDIC SURGEON to join 15-member multispecialty group, associated with JCAH-approved hospital. Associate partner status first year with guarantee plus percentage. No investment. Contact Karl Hatten, M.D., or H. Dean Andrews, Administrator, Vicksburg Clinic, Vicksburg, MS 39180.

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Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome. *Oral form* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least ⅓, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs. Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam/Roche), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return, re-administer if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam/Roche) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualized for maximum beneficial effect.

ORAL—*Adults:* Anxiety disorders, relief of symptoms of anxiety, 2 to 10 mg *b.i.d.* to *q.i.d.*, acute alcohol withdrawal, 10 mg *t.i.d.* or *q.i.d.* in first 24 hours, then 5 mg *t.i.d.* or *q.i.d.* as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg *t.i.d.* or *q.i.d.*; adjunctively in convulsive disorders, 2 to 10 mg *b.i.d.* to *q.i.d. Geriatric or debilitated patients:* 2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for use under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcoholic withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children, *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary, in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred), repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500, Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1, Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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Examine Me.

During the past several years, I have heard my name mentio in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspap magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse" and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium® (diazepam/Roche) ℞, please see the preceding page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

EW YORK N.Y. 10029

July 1981

JOURNAL of the MISSISSIPPI State Medical Association

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Address of the President

The Effect of Federal Budget Cuts on Health Care Programs In Mississippi — Part 3

School of Medicine Studies Alternatives

Feelings vs

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) Ⓡ, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

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diazepam/Roche

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.

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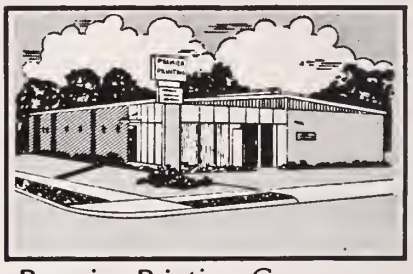
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UMC Students Choose Professors of the Year



University of Mississippi Medical Center medical students have chosen Dr. W. Forrest Hutchison of Jackson, right, and Dr. Robert L. Britt of Brandon, left, as professors of the year. Dr. Hutchison, professor of preventive medicine, was named by sophomores as preclinical professor of the year, the same recognition he received in 1972. Dr. Britt, assistant professor of pediatrics, was chosen clinical professor of the year by the senior medical school class, an honor he also received in 1978 and 1979.

Market Affecting Practice of Medicine

There is a growing body of evidence that market place forces were operating in the physician services market in the 1970s, and that the trend will increase substantially in the 1980s.

This means that, with the steady increase in numbers of physicians, more doctors are moving into areas that have had few or no doctors for years.

This is the conclusion of a report in a recent issue of the *Journal of the American Medical Association*.

The report notes that the increasing supply of physicians is curbing doctors' earnings and forcing them to seek out small town and rural areas which in the past were considered less desirable practice situations.

The conclusion is directly opposed to a "widely held but little tested position that physicians, because of their ability to induce demand for their services to reach a targeted income, are not influenced by economic market pressures," the report declares.

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Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*__INDICATIONS__: Based on a review of this drug by the National Academy of Sciences—National Research Council and other information, FDA has classified the indications as follows:
"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticanal or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Apropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, PA 19101



for mild to moderate pain

Wygesic®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**).
Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS
The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions; a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977).
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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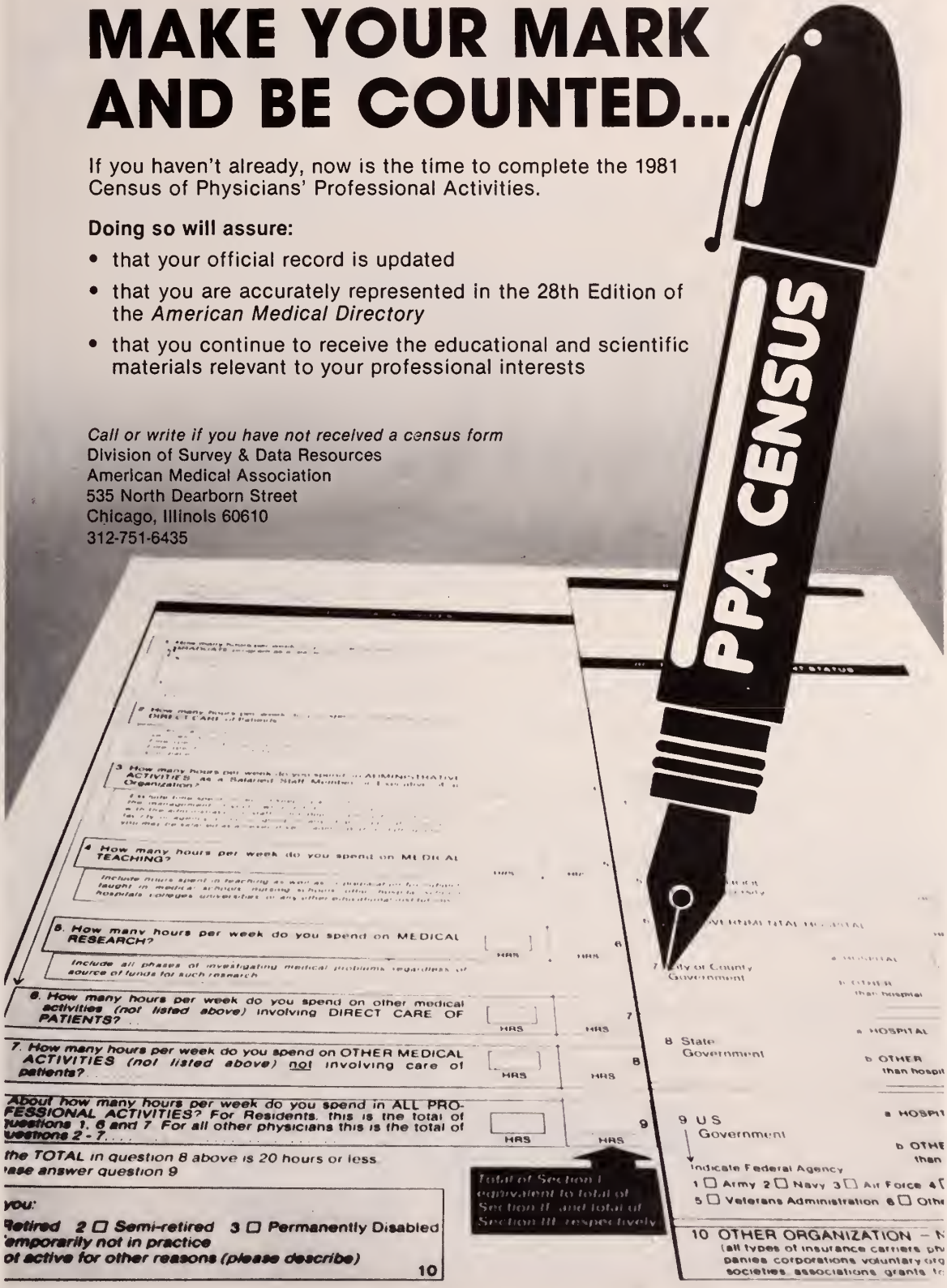
MAKE YOUR MARK AND BE COUNTED...

If you haven't already, now is the time to complete the 1981 Census of Physicians' Professional Activities.

Doing so will assure:

- that your official record is updated
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Call or write if you have not received a census form
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NEWSLETTER

July 1981

Dear Doctor:

The nation's high cesarean section delivery rate may be lowered without impeding progress toward reducing maternal and infant mortality and morbidity, says a consensus statement issued by the National Institutes of Health. A 19-member task force noted that the U.S. cesarean rate tripled from 5.5% in 1970 to 15.2% in 1978, making cesareans the tenth most common surgical procedure. The statement says alternative management could reduce the need for cesareans.

> Repeat cesarean deliveries are responsible for 30% of the overall increase, dystocia for 30%, breech presentation for 15%, and fetal distress for 15%. Free copies of the consensus statement are available from the Office for Medical Applications of Research, NIH, Building 1, Room 216, Bethesda, MD 20205.

All JCAH standards will be rewritten to focus on elements essential to quality patient care and to eliminate any unnecessary requirements and ambiguity, says the Board of Commissioners of the Joint Commission on Accreditation of Hospitals. The Board acted after reviewing a committee report studying criticism directed at the JCAH by the AMA and the American Hospital Association.

Response to the 1981 Census of Physicians' Professional Activities has been excellent, reports the AMA. Physicians who have not yet responded to the confidential survey of practice specialties and professional activities are urged to complete the questionnaire and return it. The data will appear in the 28th Edition of the American Medical Directory.

A number of magazine and newspaper publishers and television network officials have received letters from the AMA. The publishers are being encouraged to give "thoughtful consideration to refusing tobacco product advertising," and the networks are being urged to remove death-defying stunts from their programming. The letters were prepared following action of the AMA House of Delegates.

Reminders: Between now and next March, it will be necessary for physicians to return "request" or subscription cards in order to continue receiving complimentary copies of many journals which are coming under a new postal regulation. ...MSMA's 114th Annual Session, scheduled for May 2-6, 1982 at the Biloxi Hilton, will celebrate the association's 125th anniversary.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

UMC Announces Faculty Appointments

Five assistant professors and two instructors have joined the School of Medicine and centerwide faculties at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

New assistant professors are Dr. Henry Patelford Ewing, surgery (cardiac); Dr. Raymond Robert White, surgery (orthopaedic); Dr. William H. Vaughn, Jr., psychiatry and human behavior; Dr. William C. Pinkston, medicine; and Dr. John S. Addis, anatomy. Joining the faculty as instructors are Dr. George Davis Lyon, anesthesiology, and Dr. Nancy L. Hayes, anatomy.

Dr. Ewing earned the B.S. degree at Abilene Christian University and the M.D. at the University of Texas Southwestern Medical School. He interned and took residency training at the University of Mississippi Medical Center.

Dr. White, a B.A. graduate of Wabash College, earned the M.D. at the University of Illinois. He interned and took residency training at the Medical Center Hospital in Burlington, VT.

Dr. Vaughn earned the B.S. degree at the University of Mississippi and the M.D. at UMC. He interned at the US Air Force Hospital at Lackland AFB, and took residency training at the Tulane University School of Medicine. Former clinical instructor of psychiatry and neurology at Tulane, Dr. Vaughn has been in private practice in Pascagoula since 1979.

Dr. Pinkston earned the B.S. at Ole Miss and the M.D. at the Medical Center in Jackson. He also interned, took residency training and held a fellowship at UMC. Since 1979 Dr. Pinkston was chief of the pulmonary service and ICU medical director at the USAF Medical Center at Keesler.

Dr. Addis earned the B.A. at Northwestern University. He earned the Ph.D. and held the Rackham Block Grant Fellowship at the University of Michigan. From 1975-1978 he was NIH postdoctoral fellow at Yale University.

Dr. Lyon earned the B.S. degree at Mississippi State and the M.D. at University Medical Center. He took his residency training at UMC.

Dr. Hayes earned the B.A. at Northwestern University and the Ph.D. at the University of North Carolina. Since 1980, she has been postdoctoral fellow at the Max-Planck-Institut fur Biophysikalische Chemie in Gottingen, Germany.

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.
Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY. Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS. It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.
Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight ≤ 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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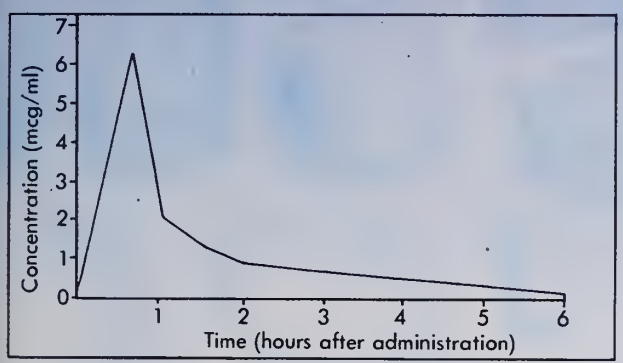
Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*



Less rash, less diarrhea than with ampicillin in studies to date.

Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

High Cure Rates with CYCLAPEN®-W (cyclacillin)		
Causative Organism	Branchitis/Pneumania†	No. of Patients
S. pneumaniae	100%	73
	95%	
Chranic Branchitis† (acute exacerbation)		
H. influenzae	92%	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	
Streptacaccal Sare Thraat†		
Graup A beta-hemalytic Streptocaccus	100%	44
	86%	
% Clinical Respanse % Bacterial Eradicatian		

†Due to susceptible organisms.

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*Based on single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

See **important information on facing page.**

CYCLAPEN®-W

(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW NAME

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Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness, emotional problems, or substance abuse, it is the only hospital of its kind in the state.

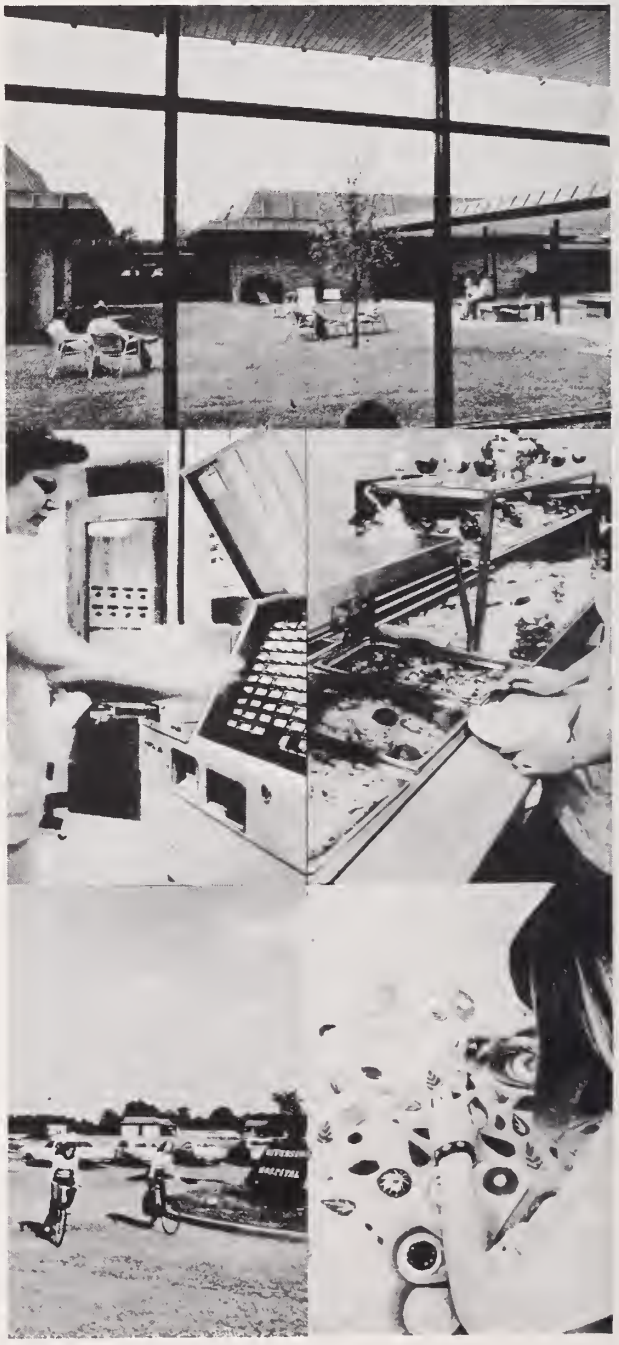
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601)939-9030

DATELINE

Home Health Services Week in Mississippi

Jackson, MS - Increased public awareness of home health services in Mississippi is one of the goals of the 141 providers who are sponsoring Home Health Services Week, August 22-28. Sponsors will coordinate efforts to enhance the industry's image with physicians and other referral sources, emphasizing home health as a cost effective, patient oriented alternative to institutional care for the state's aging and disabled population.

Newborn Screening Reminder

Jackson, MS - The State Board of Health Genetic Advisory Council reminds physicians of the importance of newborn screening for PKU and hypothyroidism. The Mississippi Legislature passed a voluntary genetic screening law and provided funds for screening and followup of indigent patients through a program in the charity hospitals and the University Medical Center. For more information, contact Sam Valentine at the SBH, P.O. Box 1700, Jackson, MS 39205.

Four State Jails Seek Accreditation

Jackson, MS - Jail Health Project Advisory Committee members completed four accreditation reviews during June. Dr. C. D. Taylor of Pass Christian and Drs. Faye G. Spruill, Robert Smith, and Ben Folk, III, all of Jackson, served as reviewing physicians. The Newton, Lauderdale, Simpson, and Harrison-District II county jails have been recommended for AMA accreditation, pending approval of the National Advisory Committee in July.

Infant Formula Regulations Opposed

Chicago, IL - Stating that there is no assurance of product safety or nutritional adequacy beyond that already provided under the Infant Formula Act of 1980, the AMA and the American Academy of Pediatrics have urged the FDA to withdraw proposed regulations of infant formulas. The organizations offered to assist the FDA in redrafting a new quality control rule, using their combined expertise and resources.

HHS to Assess Dental Radiology

North Chicago, IL - The HHS, through the National Center for Health Care Technology, will sponsor a conference to assess the appropriate and cost effective uses of dental radiology. A panel of dentists, oral surgeons, radiologists, consumers and others will examine such issues as possible risks associated with dental x-rays, rising health care costs and the use of various imaging techniques. The American public spent $730 million on dental x-rays in 1980.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

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***Incidence Less Than 1%—Causal Relationship Unknown*†**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

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Southern Democrats Give Reagan Budget Victory

All of Mississippi's Congressional delegation with the exception of Congressman Jamie Whitten were among those Congressmen recently supporting the Reagan Administration budget resolutions to cut federal spending by more than $40 billion.

Serious opposition to the economy drive came in the House, where the Democratic leadership made a party issue of a substitute budget plan that would not have cut so deeply. Whitten serves as chairman of the House Appropriations Committee. More than $2 billion of health program reductions would have been restored under the Democratic budget, but the Republican plan hewing to the Administration's lower levels easily prevailed, 253 to 176, mainly due to the support of Southern Democrats.

The Senate followed suit the following week with a budget resolution tailored to the Administration's

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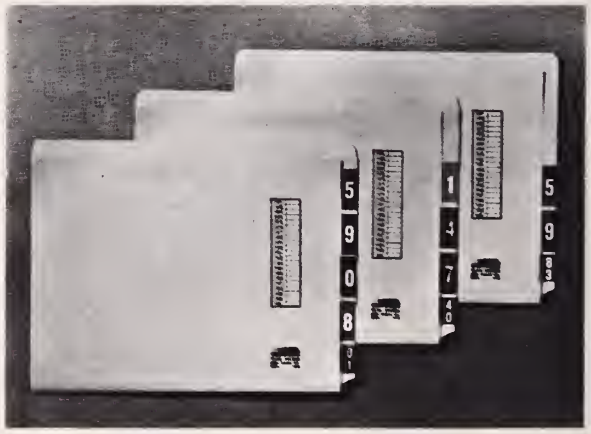
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specifications. A conference committee has ironed out the relatively minor differences between the two measures.

Only eighteen Democrats and two Republicans resisted the economy wave in the Senate as the Administration plan sailed through by a vote of 78-20. Among those voting for the measure was Senate Democratic leader Robert Byrd (D-WV). Senate Budget Committee Chairman Pete Domenici (R-NM) said the vote "clearly indicates the Senate is prepared to change its spending habits. . . . Over the long run we have started a trend toward fiscal sanity."

Before the final vote, the Senate buried, 81 to 17, a proposal by Sen. Donald Reigle (D-MI) to pare defense spending by $2 billion and increase social program spending by the same amount.

As a result of the actions, the committees of Congress are now forced to review their legislative agendas to decide where programs must be cut in order to conform to the spending ceilings imposed by the resolution.

The Senate Finance Committee, moving to cut programs within its jurisdiction, approved major changes in health programs. The committee voted to cut Medicaid spending next fiscal year by $800 million by reducing the federal minimum contribution to the states to 40 percent from the present 50 percent. At the same time, the "cap" on increased federal outlays for the program was lifted to nine percent, and the PSRO program was continued. The Reagan Administration has recommended a five percent cap on Medicaid and an end to the PSRO program.

The committee also raised the Medicare Part B deductibles and premiums, reduced the medicare nursing differential from the present 8.5 percent to 4.5 percent, and made retired federal employees' private health insurance pick up the tab first before Medicare kicked in. Some $1.2 billion of Medicare spending would be saved.

The House Ways and Means Health Subcommittee is considering similar legislation.

The House budget vote was preceded by intense lobbying by both sides. Democratic committee chairmen warned in House speeches that the House's hands would be tied to the Reagan economies for the rest of the year if the President's plan were approved.

Reagan met personally with most of the Democrats who finally voted this way. The 63 bolting Democrats provided an easy win for the Administration as they joined all Republican members of the House.

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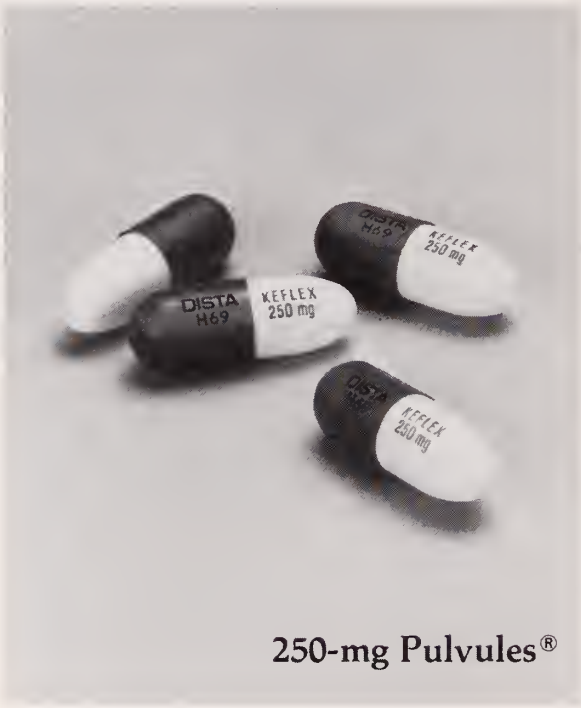
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Liver Abscess

TOM GLADFELTER, M.D. and MARK BROOKS, M.D.
Jackson, Mississippi

Liver abscess is a serious, infrequent disease which is potentially fatal if left untreated. It is most often pyogenic in nature, and is less often amebic. The epidemiology of this disease has changed considerably in recent years. In previous years it was predominantly a disease of the young adult which followed an appendicitis rupture. In recent years it has evolved into a disease of the elderly, associated with intraabdominal infection, malignancy or bacteremia; it is also seen in young adults, in association with blunt or penetrating injury of the liver.[1-2] The microorganism most often recovered from the abscess is reported as *Escherichia coli*.[2-4] Streptococci, anaerobes, and staphylococci were also found in many cases,[5] but the incidence varied considerably among previous reports. The high mortality rate of this disease has also declined considerably in the past few decades, presumably due to better diagnosis and treatment.[6-7]

In order to examine the most recent significant aspects of the clinical picture of liver abscess in the Jackson metropolitan area, medical records from four major hospitals from 1976 to 1980 were reviewed.

The four major hospitals in the Jackson metropolitan area have a total of 1,582 hospital beds, and serve a population of approximately 300,000 people. The medical records indicating discharge diagnosis of liver abscess with admission date between January 1, 1976 to December 31, 1980 were reviewed. In about 30% of the cases, the diagnoses were not confirmed by either exploratory surgery, aspiration or autopsy. These patients were excluded from this analysis. Subphrenic abscesses and perihepatic abscesses were also excluded if differentiation from a true intrahepatic abscess could be made from the record.

There were 17 cases of liver abscess identified, with the diagnosis being confirmed in 15 by surgery, in one by closed needle aspiration, and in one by postmortem examination. During the same period of time, there were 369,862 hospital admissions, giving an incidence of only 0.0046% of all hospital admissions for this disease. Of the 17, nine were female and eight were male. The distribution by age is illustrated in Table I.

The operation note and autopsy report showed 12 cases with single abscess and four cases with multiple abscesses. The locations of the 12 single abscess were in the right lobe in eight cases and in the left lobe in two cases. The remaining two cases were not properly recorded. In 53% of the cases (9 of 17), no definite source of infection or contributory event could be identified. In about 24% of the cases (4 of 17), infection was documented at another site with the same microorganism in two soft tissue abscesses, one pneumonia, and one gum infection. Taking the age into consideration, penetrating wound was the major cause (2 of 3) in patients between the age of 21 and 40. Diabetes mellitus was found in four cases, and all of those patients were all over 60 years of age.

TABLE 1
AGE DISTRIBUTION OF 17 PATIENTS

Age Group	*Number of Patients*	*Percentage*
0-20	3	18
21-40	3	18
41-60	3	18
61-80	8	47

From the Department of Family Medicine, University Medical Center, Jackson, MS.

The microorganisms recovered from the abscesses are summarized in Table II. No amebae were recovered or confirmed in any of these patients.

Eighty-eight percent of the cases (15 of 17) recovered from the illness. Twelve percent (2 of 17) died, one within eight hours after admission from overwhelming sepsis, and the other after a prolonged course of cancer cachexia and congestive heart failure.

Discussion

In the past five years, liver abscess has been a rare disease in the Jackson metropolitan area. The incidence of hospital admission for liver abscess in this area (0.0045%) is lower than the reported incidence in the literature, which varies from 0.02% to 0.007%.[1-4] The 17 cases identified obviously are less than the true occurrence of this disease. Some patients died without the benefit of surgery or aspiration; others died without autopsy; and some patients recovered with antibiotic therapy without full recognition of this disease. These cases were therefore under the threshold of being detected.

Even with this small number of patients, the age distribution is in agreement with several recent reports, i.e., liver abscess affects mainly older people.[2-3, 8] The source of infection is difficult to determine in 53% of the cases, but in about 25% of the cases a distant site of infection with the same microorganism was found. It seems that hematogenous spread of the infection to the liver is likely. High incidence of biliary tract infection as reported[2-4] was not found in this study, which is probably due to the exclusion of perihepatic abscess in this analysis.

TABLE II
MICROORGANISMS RECOVERED FROM ABSCESS

Microorganism		*Number of Patients*
Aerobes		6
Staphylococcus aureus	2	
Group A Beta-streptococcus	1	
Alpha-streptococcus	1	
Klebsiella	1	
E. coli	1	
Anaerobes		5
Peptostreptococcus	2	
Bacteroides	2	
Anaerobic streptococcus	1	
No growth		6
Ameba		0
Total		17

There is a high incidence (about 25%) of diabetes mellitus found in the patient population of this study. All of them were mature onset diabetic patients under satisfactory metabolic control prior to the diagnosis of liver abscess. This association has been reported before,[3-5] but the reason for this association is not clear.

The other clinical aspects of these 17 patients were also quite similar to other reports. The disease affects both sexes equally. The abscesses were mostly single and located more frequently in the right lobe of the liver.

The microorganisms recovered from the abscess were 45% anaerobic and 55% aerobic. A high incidence of anaerobic microorganism as the cause of liver abscess has been reported recently.[5] In contrast to previous knowledge that the predominant infective microorganism is *E. coli*, the findings here suggest that anaerobic microorganisms are predominant agents in liver abscesses. This also possibly reflects the improvement of culture techniques available to all the hospitals in the past five years.

It is interesting to know that almost all patients had received antibiotics before the cultures were taken from the abscesses, which probably accounts for no growth in some of the cases. However, no difference in the usage of antibiotics could be detected between those microorganisms that were recovered and those that were not.

It is important to know that microorganisms could still be recovered from the abscess after several days (up to two weeks) of multiple antibiotic therapy. This finding indicates the inappropriateness of antibiotic therapy alone. In spite of the fact that successful treatment of liver abscess without surgical drainage has been reported recently,[9] the persistence of microorganism justifies the promptness of surgical drainage.

It is quite interesting that no amebic abscess was identified in this series. A complete investigation for amebic diagnosis would include direct examination of pus, stool and tissue, along with serum hemagglutination inhibition and/or complement fixation. This extensive investigation for amebae was not carried out in each of the 17 cases, and it is conceivable, though highly unlikely, that an amebic abscess might have been drained surgically and cleared with empiric usage of metronidazole. A more likely assumption is that the true incidence of amebic liver abscess has declined in this area.

The overall mortality rate of 12% in this report is lower than several recent reports.[2-3, 6, 10] It is especially significant with the fact that this report represents the area-wide result with several hospitals

rather than one center's confirming the recent trend of decline in mortality rate of this disease due to better diagnosis and effective therapy.

In conclusion, surgical drainage of abscess with wide antibiotic coverage remains the treatment of choice. From the findings of high incidence of anaerobic microorganism, antibiotics effective against both anaerobic and aerobic microorganisms should be used in all patients. ★★★

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References

1. Oschner, A., DeBakey, M. and Murray, S.: Pyogenic abscess of the liver. II. An analysis of 47 cases with review of the literature. Am. J. Surg. 40:292-319, 1938.
2. Rubin, R. H., Swartz, M. N., and Malt, R.: Hepatic abscess: Changes in clinical, bacteriologic and therapeutic aspects. Am. J. Med. 57:601-610, Oct. 1974.
3. Lazarchick, J., deSouza e Silva, N. A., Nichols, D. R., and Washington, J. A. II. Pyogenic liver abscess. Mayo Clin. Proc. 48:349-355, May 1973.
4. Pitt, H. A., and Zuidema, G. D.: Factors influencing mortality in the treatment of pyogenic hepatic abscess. Surg. Gynecol. Obstet. 140:228-234, Feb. 1975.
5. Sabbaj, J., Sutter, V. L., and Finegold, S. M.: Anaerobic pyogenic liver abscess. Ann. Int. Med. 77:629-638, Oct. 1972.
6. Satiani, B., and Davidson, E. D.: Hepatic abscesses: Improvement in mortality with early diagnosis and treatment. Am. J. Surg. 135:647-650, May 1978.
7. Silver, S., Weinstein, A., and Cooperman, A.: Changes in the pathogenesis and detection of intrahepatic abscess. Am. J. Surg. 137:608-610, May 1979.
8. Heymann, A. D.: Clinical aspect of grave pyogenic abscesses of the liver. Surg. Gynecol. Obstet. 149:209-213, Aug. 1979.
9. Maher, J. A. Jr., Reynolds, T. B., and Yellin, A. E.: Successful medical treatment of pyogenic liver abscess. Gastroenterology 77:618-622, Oct. 1979.
10. Cheung, N. K., Malfitan, R. C., Najem, A. Z., and Rush, B. F. Jr.: Pyogenic liver abscess. Am. Surg. 44:272-278, May 1978.





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Malignant Fibrous Histiocytoma Arising in Bone

JUNE BLOUNT, M.D., FRAZIER WARD, M.D., and RONALD GRAY, M.D.
Jackson, Mississippi

A 75-YEAR-OLD WHITE MAN was referred to the University of Missisippi Medical Center with a four-month history of increasing right knee pain. Treatment with various antiarthritic medications had produced no relief. He had been hospitalized elsewhere and found to have a destructive lesion in the metaphyseal region of the distal femur.

Roentgenograms of the distal right femur demonstrated an 8 x 4.5 cm lytic, slightly expansile lesion with poorly demarcated borders in the distal femoral metaphysis. The lesion irregularly invaded and destroyed the medullary and cortical bone of the metaphysis and adjacent diaphysis, resulting in a pathologic fracture at the anterior margin. There was very faint periosteal reaction, and the soft tissue planes surrounding the lesion were slightly displaced. No soft tissue calcification was present (see Figure 1).

Biopsy with a Craig needle of 3 mm width, under local anesthesia, yielded a direct, immediate diagnosis of malignant fibrous histiocytoma. This procedure, with a minimum of complications, facilitates diagnosis without protracted extensive workup of deep lesions of bones.

The bone scan was positive in this area. The metatastatic workup was negative.

The thigh was amputated 33 cm above the knee joint, approximately 20 cm superior to the lesion. The patient is alive nine months postamputation and has received no further treatment.

Pathology

Grossly, the tumor was firm and uniformly pale gray. It virtually filled the medullary cavity of the femoral metaphysis and adjacent diaphysis. The tumor extended through the bone in the metaphyseal region, and the cortex in this area was thinned and



Figure 1. Radiograph of distal right femor demonstrating lytic lesion with focal periosteal reaction and distortion of soft tissue planes (arrows).

From the Departments of Radiology and Orthopedics, University Medical Center, Jackson, MS.



Figure 2. Photograph of gross specimen showing bone destruction with direct extraosseous extension of tumor. Arrows outline the lesion.

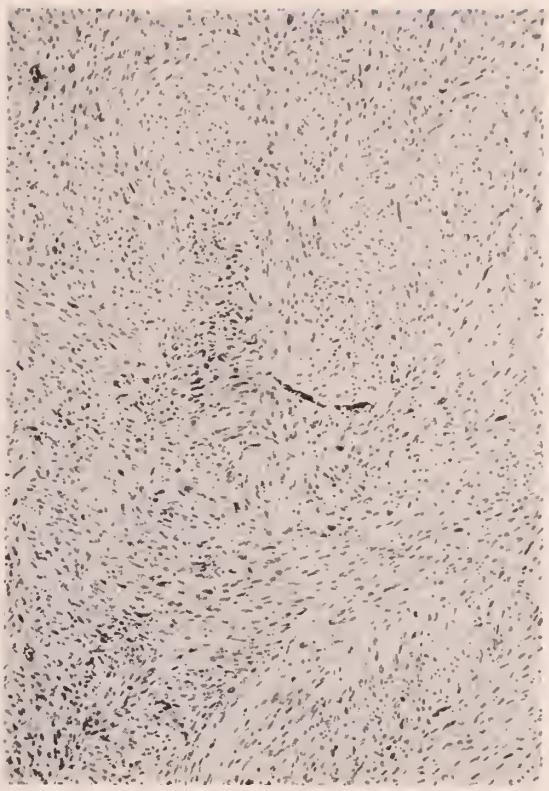


Figure 3. Low power photomicrograph of tumor illustrating storiform arrangement of fibrocytic cells, typical of malignant fibrous histiocytoma of bone (original magnification ×50).

eroded, resulting in an irregular transverse supracondylar fracture. In addition, the tumor invaded the trabecular bone of the femoral condyles (see Figure 2).

Microscopically, the tumor was composed of two distinct cell types. The predominant cell was spindle shaped, resembling a fibrocyte, and was often arranged in a whorled "storiform" pattern. Distributed unevenly throughout the tumor were cells resembling histiocytes having abundant, occasionally foamy cytoplasm, and relatively large, often convoluted, nuclei with large eosinophilic nucleoli. Cytologic features of malignancy varied from field to field, but most sections demonstrated bone destruction, evident from scattered collections of necrotic osseous debris. Lymphocytes and a few eosinophils were scattered throughout the tumor (see Figure 3). The surgical margins were free of tumor, and no positive lymph nodes were present. The final histologic diagnosis was malignant fibrous histiocytoma.

Discussion

The malignant fibrous histiocytoma may be intraosseous, extraosseous, or both.[1-3, 5, 7]

The histiocyte is derived from the primitive reticulum cell and belongs to the reticuloendothelial system. It is phagocytic, but is also capable of differentiation into a fibroblast.[1-5]

Microscopically, the tumor is characterized by bundles and whorls of spindle cells with a storiform arrangement.[1-3, 7] Spanier et al,[5] in reporting eleven bone lesions classified as malignant fibrous histiocytoma, noted inflammatory cells, most commonly lymphocytes, but occasional plasma cells and eosinophils, "percolating" the tumor. Similar finding were noted in the present case.

Sanerkin and Woods[6] reported two cases in which a malignant fibrous histiocytoma developed in relation to an enchondroma in a long bone. They appear to have arisen from dense fibrous tissue surrounding necrotic areas in the enchondromata.

Lymphatic and blood borne metastases have been reported by Spanier et al[5] and Feldman and Lattes.[1]

Prognosis is poor. Nine of eleven cases reported by Spanier et al[5] developed pulmonary metastases withing 21 months.

Differential diagnosis would include metastasis, multiple myeloma, reticulum cell sarcoma, fibrosarcoma, and osteolytic osteogenic sarcoma. ★★★

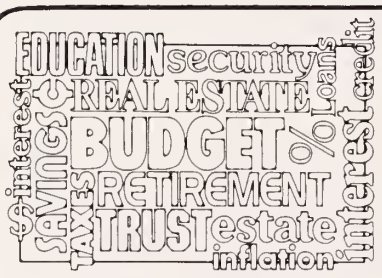
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References

1. Feldman, F., and Lattes, R.: Primary malignant fibrous histiocytoma (fibrous xanthoma) of bone. Skeletal Radiology, 1:145-160, 1977.
2. Feldman, F., and Norman, D.: Intra- and extraosseous malignant histiocytoma (Malignant fibrous xanthoma). Radiology 104:497-508, Sept. 1972.
3. Kahn, L. B., Webber, B., Anstey, L., and Heselson, N. G.: Malignant fibrous histiocytoma (Malignant fibrous xanthoma: xanthosarcoma) of bone. Cancer 42:640-651, 1978.
4. Pear, B. L.: The histiocyte in radiology. Am. J. Roent., Rad. Ther. and Nucl. Med. 110:159-165.
5. Spanier, S. S., Enneking. W. F., and Enriquez, P.: Primary malignant fibrous histiocytoma of bone. Cancer 36:2084-2098, 1975.
6. Sanerkin, N. G., and Woods, C. G.: Fibrosarcomata and malignant fibrous histiocytomata arising in relation to enchondromata. Bone and Joint Surg. 61-B:366-372, Aug. 1979.
7. Murray, R. O. and Jacobson, H. G.: The Radiology of Skeletal Disorders. Edinburgh London and New York, Churchill Livingstone, 1977, Second Edition, Vol. 2, p. 1472.



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COST & REGISTRATION: The cost is $295.00 which includes fees, lunch, coffee, & seminar materials.

FOR FURTHER INFORMATION, call the University of Southern Mississippi, Department of Business & Industrial Programs at (601)266-4263 or 266-4295 or 982-6210.

Detach and Mail to:
Darryll W. Barksdale, Coordinator, Department of Business & Industrial Programs, University of Southern Mississippi, Southern Station, Box 5055, Hattiesburg, Mississippi 39401.

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Address of the President

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

IT IS INDEED AN HONOR for me to stand before this auspicious group this morning in the Biloxi Hilton on the beautiful Mississippi Gulf Coast. It bypasses tenfold my wildest imagination or any dream I might have had as a young boy, growing up as a baby of ten children of a row farmer on Nanih Wayia Creek in Winston County, just 18 miles southeast of the Louisville Post Office. I want you to know that Jean and I do appreciate the honor that you bestowed upon us by allowing us to serve as your President and First Lady of our MSMA this year. I have been pressured by many, and big money has been offered, but on principle, I will not run for reelection. After all, what type of man would try to usurp a fellow Winstonian by the name of Faser Triplett?

After a year in office, traveling about the state talking to medical societies and writing a President's Page for the JOURNAL (which I enjoyed very much), I know you are asking — what else can ole Paul tell us? Well, I can and will tell you some things this morning that you may be surprised to hear; but I would like to say that I believe it, and it is from the bottom of my heart.

This morning I am almost a complete optimist. I would say complete, but some wise guy would say that that doesn't sound like a radiologist. We should first of all be proud that we are Americans. Just think what has happened during the past several days. We saw an attempt on our beloved President's life which caused some chaos, but the system did not waver. Then shortly after, we saw the launching and reentry of our space shuttle, the first ever of its kind. America never fails to amaze us. Always to this date when we needed a leader or an event to rally the people, one has stepped forward or happened.

This morning I am standing facing one of the greatest audiences of people that you can imagine. As I have stated already, there is nothing to equal being an American citizen. Then to go one step farther, I would like to ask you — what is the greatest profession in the world? Without blinking an eye or stuttering, I have only to remind you that it is medicine. So, "how great it is" to be a vital cog in the greatest profession in the greatest country of the world.

As I view this gathering, one might ask why aren't more of our colleagues present? In fact, standing here approximately 12 months ago, I asked myself that question and was almost bitter because they weren't here. Today, somewhat smarter, I hope, through my year of activity, I have developed a new concept and outlook. It is no doubt as I gaze out that you are the salt of the medical profession. Stealing from the Marine recruitment slogan, all we need for leadership in Medicine are a few good men, and I am here to tell you I believe that we have them and we are going to have some more.

The Mississippi State Medical Association is on the march and I would like to tell you why I think that it is so. First, we have a cause; that is to keep American Medicine as a free enterprise system and give the best patient care in the world. The way that we have and will continue to accomplish this is through our membership. We may not be here in body this morning, but I am here to tell you that the physicians of Mississippi are the best damn joiners in the world. At this time 80% of the physicians of Mississippi are members of the MSMA. Not too many state organizations can top this.

Fellow physicians, we have something to brag about. It didn't happen overnight. Work through the years has brought about these results. Lastly, I would like to commend the leaders of our association of the past and present for their selection of our executive officers. I would like at this time to especially recognize Mr. Charlie Mathews for work he has done, forethought that he has had, and for the fine staff he has assembled. I will mention no more names lest I miss one or show partiality.

When we stop to reflect about the social unrest during the past two decades, it is amazing that American Medicine withstood the onslaught. Oh yes, we took some bumps and bruises, but when compared to other institutions, we at least came out with an A−. The AMA and the MSMA cannot be everything to

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President, Mississippi State Medical Association, 1980-81. Read before the House of Delegates, 113th Annual Session, Biloxi, April 27, 1981.

everyone, but those who criticize us have not come up with a better program. It is easy to criticize your neighbor and friend, but very difficult at times to out contribute. All we need is to keep our heads screwed on correctly, remembering at all times that our only function is to care for our patients. As President Hunter stated in his address at the AMA Annual Meeting last summer and I quote:

> "Humanism in Medicine, after all, is just another way of saying 'I care' and patients are telling us that while the delivery system, and the people in it, care for them very well, does the system and the people in it, care *about* them as well."

Just like America, the MSMA House of Delegates steps forward each year and tells the Board of Trustees what they want and in essence how they want it done. A few years ago when the malpractice insurance problem was indeed a problem with most commercial carriers saying "no" and those that weren't saying "no" were skyrocketing their premiums, this House of Delegates went into action and told the officers to go to work to form an insurance company for Mississippi doctors. This was accomplished and is serving a great need. All members do not belong, but they should understand that their freedom of choice and the premiums that they pay are the direct results of the action of the House of Delegates of the MSMA. The MSMA is continually on the prowl trying to catch those who are trying to practice medicine without a license. We do this in many ways, but our legislative watchdog, Bucky Murphy, does an outstanding job. Through our Journal, with Patsy Silver, the coordinator, we try to keep the membership informed. I could go on and on, but you sitting there already know what's going on. We will expect you to inform your brethren.

We have strived for involvement this past year and I believe we have accomplished this to some degree. We have asked the Board to give the MSMA more representation at the AMA meeting. At the present time we are encouraging our alternate delegates to attend by picking up some of their expenses. We also have a working Health Education Committee. We hope to have some input and influence on the development of health education in the public schools. We have initiated a corporate visitation program, patterned after the AMA program. I believe that this will be one of the more important programs that the MSMA has initiated.

In closing, I would like to make a few recommendations to you. I know that some of these are already on the mind of my successor.

1. We need more political involvement. Yes, I mean we need more monies contributed.

2. I would like to see the MSMA, through the local components, encourage their officers and members to attend the annual AMA Leadership Conference in Chicago. These conferences are extremely good and if one doesn't come away with a feeling of excitement and achievement, then he should have his vital signs checked.

3. Lastly but probably the most important, I would encourage the MSMA to organize their own annual leadership conference. Everyone would be encouraged to attend, but much effort should be put forth to see that members of each component society would be present. These would be those few good men needed in Medicine.

In closing let me remind you once more how great we are. In the 17th century the barbers and surgeons were arguing among themselves about who was the greatest. The AMA had its inception in 1847. Many trials and tribulations have faced Medicine since then, but we have stood the test of time and there is no doubt in my mind, nor should there be in yours, that American Medicine and its men and women will endure forever. ★★★

Third in a series examining effects of federal budget cuts on health care programs in Mississippi.

Faced With Federal Budget Cuts, School of Medicine Studies Alternatives

CHARLES L. MATHEWS and PATSY SILVER

PRESIDENT REAGAN has proposed cuts in federal funding for Medicaid, Health Professions Training and Categorical (Health) Grant Programs. To determine just what effect these proposed cuts might have in Mississippi, JOURNAL MSMA recently interviewed Mr. Billy F. Simmons, Director of the Mississippi Medicaid Commission; Dr. Norman C. Nelson, Vice-Chancellor and Dean of the University of Mississippi School of Medicine; and Dr. Alton B. Cobb, Executive Officer of the Mississippi State Board of Health. This issue presents the interview with Dr. Nelson.



Editorial Note: The Reagan Administration is proposing an end to federally funded general institutional support and construction grants for medical schools. Funding for the National Institutes for Health would be continued but only at current levels. Additionally, total federal funds available for loans to medical students would be reduced, and no new scholarships would be available under the National Health Service Corps Program. Federal funding available for medical training programs would be refocused on specifically identified specialties such as family medicine, internal medicine and pediatrics. Other Reagan Administration proposals dealing with Medicaid and block grants would also impact on medical schools.

JOURNAL MSMA: Dr. Nelson, the Reagan Administration proposals dealing with medical education touch on several areas. What would their impact be at the University of Mississippi School of Medicine?

DR. NELSON: Looking at the area of student loans and scholarships first, I believe it's significant to note that last year 453 of our 598 medical students received some type of financial assistance. Excluding 13 National Health Service Corps scholarships, this assistance totalled some $1,971,836; and the greatest portion of this was in the form of federally insured loans. So we foresee some serious deficits if federal loans and scholarships are cut back.

JOURNAL MSMA: What about private contributions as a source of funding?

DR. NELSON: We have some of these now but not enough. There are also funds available from lending institutions, but as we all know, interest rates are very high.

JOURNAL MSMA: What about state funds?



DR. NELSON: As you know, we do have a State Medical Education Loan Program. Last year 24 of our 453 medical students receiving financial assistance were on this program.

JOURNAL MSMA: What effect will the Reagan Administration proposals to end general support and construction grants have on the University of Mississippi School of Medicine?

DR. NELSON: By general support I assume we are speaking primarily about the end of what have been called capitation grants. Fortunately we saw the handwriting on the wall on this one several years ago, and we have been able with the help of the state legislature to avoid any great dependence on capitation grants. Our last federal construction loan was also several years back in the form of $3.6 million for the Library Learning Resource Center.

JOURNAL MSMA: Speaking about the state legislature, there was some discussion when the medical school increased to a graduating class of 150 students that you were short of faculty and basic science support. Is this the case today?

DR. NELSON: A thanks is due to our state legislature for the great strides that have been made in funding the basic science program and faculty. We have 20 new faculty positions approved for this year.

JOURNAL MSMA: How do you view the Reagan Administration proposal to refocus available federal funds for medical training programs on the specialties of family medicine, pediatrics and internal medicine?

DR. NELSON: Mississippi's needs for doctors are in those specialties, so I don't believe the proposal would impact unfavorably on our state.

JOURNAL MSMA: What about the desires of the students? Are they selecting these specialties?

DR. NELSON: In our graduating class this year of 145 students, 89 have signed up to train in the specialties of pediatrics, family medicine and internal medicine. This has been the trend for the past few years. That is, some two-thirds of our graduates are entering what are called the primary care specialties.

JOURNAL MSMA: Speaking of our graduates, there have been a lot of statistics thrown out by different people for different purposes as to whether or not they are locating in Mississippi. What are the real facts on this?

DR. NELSON: This statistic can be verified. Of those graduates of this four-year medical school who have completed internship, residency and any service obligation, 68 percent are practicing in Mississippi.

JOURNAL MSMA: Under the Reagan Administration's proposals, federal funding for the National Institutes of Health (NIH) will not be cut but will remain at its current level. How will this affect medical schools?

DR. NELSON: Currently we are receiving some $6 million in NIH grants. A continuation of funding at only current levels will hurt, if for no other reason, because of inflation.

JOURNAL MSMA: What about the Reagan Administration proposals dealing with Medicaid and block grants for health? What will be their impact here if they are enacted by Congress?

DR. NELSON: Some 24 percent of our patient care monies presently come from the Medicaid program. So any reductions will be felt. As for the block grant proposal, the most significant program to us would be maternal and child health. We currently receive about $500,000 from this program. The proposed 25 percent reduction would hurt us.

JOURNAL MSMA: There has been a good bit of debate recently about whether we are headed for a surplus of physicians in the next decade. What do you foresee down the road as far as a reduction in medical school enrollments?

DR. NELSON: I believe we will see the private schools reducing enrollments by the mid-eighties if for no other reason than because of increasing costs. Public supported schools such as our University of Mississippi School of Medicine will be looking at how to balance reduced federal support with increased state support while meeting the state's need for physicians and medical care.

★★★

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The President Speaking

AMA Annual Meeting Highlights

R. FASER TRIPLETT
Jackson, Mississippi

I have recently returned from the annual meeting of the AMA in Chicago. I would encourage each of you at some point in your medical career to attend one of these annual sessions. I believe that you, like myself, would come home with a good feeling about our organization, our leadership and particularly about the opportunity that every physician has to be heard and to participate in the formulation of policy which we as a group will espouse. You would also be impressed with the quality of debate on the very serious issues that confront our profession. Because of space, I can highlight only a few of these issues at this time.

In one of its more important actions, the House endorsed a new functional profile for the AMA. An indepth analysis of AMA functions, activities and resource needs had been made by the staff and outside consultants. This resulted in the identification of a set of basic functions for the AMA with representation of the profession as the most prominent function.

Resolutions calling for a review of the need for changes in the present diverse system of examinations for medical licensure, and for an evaluation of the effects of a change from the present licensing process to the proposed Flex I and II concept were discussed.

Lengthy and thoughtful discussions were held on reports dealing with what if anything the profession should do since we have now taken a stand against PSRO and the National Health Planning Act. In anticipation of the withdrawal of federal support for the PSRO program, the Council on Medical Service has begun to examine alternative voluntary quality assurance mechanisms and methodologies now available and operating under professional direction. The House also endorsed the Council's position that each community, in cooperation with the local medical society, should make its own decision as to whether a voluntary health planning program should be instituted. It also emphasized that the local medical society has a special obligation to its membership and to the community at large to provide leadership and support of voluntary community health planning programs so as to ensure

(Continued on page 186)

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 7

JULY 1981

Breast Cancer Screening

Survival rates for patients with breast cancer vary as to the extent of the disease at the time of diagnosis. Eighty-five percent of women with localized disease survive five years, while only ten percent of women who present with distant metastasis live this long. Early detection techniques have been developed but require good physician-patient cooperation to be effective.

Certain risk factors are important in breast cancer screening. The age of the patient is a definite measurable factor. The disease rarely occurs before age 30, increases dramatically between 30 and 50 years, and slows after age 50. The family history is also an important risk factor. A two to three-fold increased risk is present in women who have a sister or mother with breast cancer. Fibrocystic disease of the breast also increased the risk for the development of mammary cancer.

Periodic clinical examination and mammography appear to complement each other in reducing cancer mortality. In a study by the Health Insurance Plan (HIP) 31,000 women age 40 to 64 years were followed for one year. Forty-five percent of the breast cancers would have been missed if a clinical examination had not been performed and thirty-three percent of the tumors detected would have been missed if a mammography had not been performed. The study concluded that mammography is justified as a screening device in women over age 50 if the radiation dose can be kept under 1 rad.

Current recommendations based on the above information are as follows: (1) Women with no specific risk factor should have an annual physical examination, a breast self-examination each month, and a mammography at age 50 and periodically thereafter. (2) Women with a positive family history of breast cancer should have a physical examination every six months, a breast self-examination each month and a mammography at age 50 and periodically thereafter. (3) Women who have had a mastectomy previously should have a physical examination every six months, a breast self-examination each month and a mammography annually.

The above program of physical examination, breast self-evaluation and mammography should significantly reduce the mortality from the most common cancer affecting women.

GEORGE H. MARTIN, M.D.
Associate Editor

Medico-Legal Brief

Hospital Negligent in Granting Surgical Privilege to Physicians

A hospital was negligent in granting orthopedic surgical privileges to a physician, the Wisconsin Supreme Court ruled.

On July 11, 1975, the physician unsuccessfully attempted to remove a pin fragment from the patient's right hip. During the course of the surgery, the patient's common femoral nerve and artery were damaged, causing a permanent paralytic condition of his right thigh muscles with resultant atrophy and weakness and loss of function.

Fifteen months later the patient filed suit against the operating physician and the hospital. The physician settled the claim for $140,000, and the patient proceeded with his action against the hospital. The claims against the hospital charged it with negligence in allowing the physician to perform orthopedic surgery.

A jury found the hospital negligent in granting privileges to the physician and apportioned 80 percent of the causal negligence to the hospital. Damages were awarded in the sum of $405,000 for past and future personal injuries and impairment of earning capacity. An appellate court affirmed.

On appeal, the Supreme Court affirmed the decision and agreed that the evidence supported a finding of the hospital's negligence. A hospital owes a duty to its patients to use due care in the selection of its medical staff and the granting of specialized surgical

privileges. The court said that in investigating medical staff applicants a hospital, at a minimum, should: require completion of the application and verify accuracy of applicant's statements, especially those pertaining to his medical education, training and experience; solicit information from applicant's peers, including those not referenced in his application, who are knowledgeable about his education, training, experience, health, competence and ethical character; determine if he is currently licensed to practice in the state and if his licensure or registration has been or is currently being challenged, and inquire whether applicant has been involved in malpractice actions and whether he has lost medical organization membership or medical privileges at any other hospital.

The hospital failed to perform these minimal requirements and its negligence caused the patient's injuries, the Supreme Court concluded. — *Johnson v. Misericordia Community Hospital,* 301 N.W.2d 156 (Wis.Sup.Ct., Jan. 6, 1981)

THE PRESIDENT SPEAKING

(Continued from page 184)

that goals of maintaining and improving the quality, efficiency, availability, accessibility and cost effectiveness of the health care delivery system are met.

One of our own AMA delegates, Dr. Lamar Weems, chaired Reference Committee C, which had many important items on the agenda, including the subject of examinations for medical licensure. This was a most important responsibility which Dr. Weems performed quite ably. That he was chosen from so many by the leadership confirms that they recognize his ability, and our House of Delegates acted wisely in choosing him as one of our representatives.

I would encourage each of you to avail yourself of every opportunity to stay aware of these and all the other important issues that confront our profession today. Most are discussed in the *AMA News,* so get in the habit of reading it weekly.

LETTERS

Sirs: The 1980 session of the Mississippi Legislature passed a voluntary genetic screening law which would allow for newborn metabolic screening for phenylketonuria and hypothyroidism. Funds were appropriated to the Mississippi State Board of Health for the screening and followup of indigent patients.

The screening test will be taken within the first seventy-two (72) hours of life and forwarded to a central laboratory in order to assure uniformity and accuracy. Indigent children who have an initial positive screening test will then be contacted for confirmation with followup and treatment assured. This program will begin in the charity hospitals and the University Medical Center. Expansion will occur later to disadvantaged patients in the remainder of our state. Newborn screening for private patients will continue as before with private medical providers. The Mississippi State Board of Health Genetic Advisory Council has recommended that all medical providers throughout the state be reminded of the importance of newborn screening for PKU and hypothyroidism.

We support this effort and would encourage those not screening for those disorders to consider doing so. Only by identifying and treating these disorders in the immediate newborn period can the incidence of mental retardation be reduced.

Claude Earl Fox, M.D., Chief
Bureau of Personal Health Services
Miss. State Board of Health
P.O. Box 1700
Jackson, MS 39205

POSTGRADUATE CALENDAR

July 23-25, 1981
Advanced Cardiac Life Support
Meridian, Mississippi

October 14-17, 1981
Family Practice Update
Jackson, Mississippi

December 10-11, 1981
Perinatal Postgraduate Course
Jackson, Mississippi

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, Mississippi 39216. Phone: (601) 987-4914.

MEDICAL ORGANIZATION

Dr. James Waites Named Guardian Society Chairman



Dr. Waites



Dr. Conerly

Members of the University of Mississippi Alumni Association's Guardian Society elected Dr. James C. Waites of Laurel as 1981-82 chairman during the society's sixth annual meeting, April 26, 1981. Dr. A. Wallace Conerly of Jackson was named vice chairman.

The Guardian Society serves as a vehicle for exceptional gifts to the various health education endeavors pursued by the University of Mississippi Medical Center. Gifts valued at more than $16,000,000 have been donated by 321 society members, including dentists, physicians, and nurses. The society was formed in 1972 with an enrollment of 21 members.

Society members act as trustees in overseeing allocation of gifts, which may be either restricted or undesignated. Unrestricted gifts are used to fund special projects and to conduct administrative affairs, primarily recruitment of new members. Designated gifts have funded such programs as: continuing medical education in various medical disciplines; loans for students through the Guyton and Levine loan programs; fellowships in orthopedics, family medicine, and obstetrics and gynecology; scholarships; the AMA-ERF program; and the proposed Center for Continuing Health Professional Education for the University's Jackson campus.

For additional information about the Guardian Society, contact the Office of Alumni Activities, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

145 Receive M.D. Degrees At UMC Commencement

Thomas Nichols Skelton of Jackson was recognized as top medical school graduate in University of Mississippi Medical Center Commencement ceremonies in Jackson, May 31.

Dr. Skelton, who earned his degree summa cum laude, received the University's Leathers Award as the graduating medical student with the highest academic average. Son of Mr. and Mrs. William A. Skelton, Jr., Dr. Skelton will intern at the University of Texas Southwest Medical School Affiliated Hospitals in Dallas. He earned the B.A. and B.S. degrees at the University of Mississippi.

Congressman G. V. Montgomery delivered the Commencement address to some 326 UMC graduates and their guests at city auditorium. The graduate total included 145 for the M.D.; 75 for the B.S. in nursing; 30 for the D.M.D.; and six for the master of science in nursing. Eight students earned the master of science, the master of combined sciences or the Ph.D. The graduate total included 15 for the B.S. in medical record administration; 11 for the B.S. in medical technology; 12 for the B.S. in nurse anesthesiology; and 24 for the B.S. in physical therapy.

Other honor graduates in the School of Medicine were Robert L. Lewis of Woodville, Philip Travis of Blue Mountain and Richard T. Jackson, who earned their degrees magna cum laude. Cum laude graduates were Evaline McSpadden Thompson of Jackson, Paul Phelps of Columbus, Gregory W. Merritt of Jackson, Katherine Hardy Little of Jackson, Joseph Marc Majure of Louisville and Michael O. Stodard of Meridian.

Medical Assistants Hold 15th Annual Convention

Dr. Homer Horton of Tupelo and Dr. Maurice Creekmore of Greenville have been named physician advisers to the American Association of Medical Assistants, Mississippi Society. The elections took place during the society's 15th annual convention, held recently in Tupelo. Other members of the advisory board are Dr. Paul H. Moore of Pascagoula, immediate past president of the Mississippi State Medical Association, Dr. Edwin Hemness of

Clarksdale, and Charles L. Mathews, MSMA executive secretary.

Carol Lockey of Jackson was elected 1981-82 president of the society, and Myrtle Cain of Amory was named president-elect. Elected to other offices were: Mary Ellen Ladner of Pass Christian, vice president; Billie Sue Morgan of Tupelo, secretary; Carol Ann Coker of Tupelo, treasurer; and Jean Olsen of Clarksdale, executive board member. The president, president-elect and vice president were chosen as delegates to the national convention, and Jean Rains of Tupelo was named alternate delegate.

More than 150 representatives of the society's 15 chapters attended the three-day meeting. Special guest speakers were Clyde Whitaker, mayor of Tupelo, Mrs. Mabel Ann Veach of Orange Park, FL, president-elect of the American Association of Medical Assistants, and Dan Wilford of Tupelo, administrator of the North Mississippi Medical Center. Aaron J. Johnston of Jackson, executive vice president of Blue Cross-Blue Shield of Mississippi's Corporate and Provider Affairs and Government Programs, was master of ceremonies for the installation banquet.

In addition to business sessions, awards luncheon and installation banquet, the convention program included four workshops for medical assistants and a tour of the Elvis Presley Center.

Fourth Distinguished Lectureship Presented at Field Hospital



Dr. James D. Hardy of Jackson, right, president of the American College of Surgeons, was speaker for the Fourth Annual Distinguished Lectureship of Field Community Hospital in Centreville. His topic was "The Health of Medicine." Pictured with Dr. Hardy, from left, are Dr. Raymond F. Martin of Jackson, governor of the Mississippi Chapter, American College of Surgeons, and Dr. Richard Field of Centreville, former ACS governor.

Dr. Guy Campbell Receives MLA Distinguished Service Award



Dr. Guy Campbell of Jackson, left, received a standing tribute from lung association volunteers as he accepted the 1981 Mississippi Lung Association Distinguished Service Award from Dr. John Busey of Jackson, MLA past president.

Dr. Guy D. Campbell of Jackson has been named recipient of the Mississippi Lung Association's 1981 Distinguished Service Award. The award was presented at the 69th annual meeting of the Christmas Seal voluntary health organization by Dr. John F. Busey, past president and member of the MLA Board of Directors.

A native Mississippian, Dr. Campbell was born in Lauderdale and grew up in Laurel. A graduate of the University of Mississippi, he received his M.D. degree from Harvard Medical School, interned at Charity Hospital, New Orleans, and received residency training in pulmonary diseases at Mississippi State Sanatorium and in internal medicine at the Veterans Administration Hospital in New Orleans.

For eighteen consecutive years, he has served as a member of the Mississippi Lung Association Board of Directors and Executive Committee. In 1959-60 he was Mississippi Thoracic Society president; 1966-68, MLA president; 1969-70, Southern Thoracic Society president. He is currently Mississippi's representative Director on the American Lung Association Board of Directors, a position he has held since 1972.

NEW MEMBERS

ADAMS, HANS WERNER, Biloxi. Born Salzgitter, Germany, Mar. 11, 1945; M.D., Medical College of Georgia, Augusta, 1971; interned, internal medicine residency, and gastroenterology residency, same, 1971-75; elected by Coast Counties Medical Society.

BOULDIN, MARY E., Clarksdale. Born Clarksdale, MS, Sept. 29, 1930; M.D., University of Tennessee College of Medicine Memphis, 1959; interned John Gaston Hospital, Memphis, one year; ob-gyn residency, same, 1961-64; elected by Clarksdale and Six Counties Medical Society.

CHANSANCAHI, MULUT, Clinton. Born Thailand, Nov. 10, 1937; M.D., Chulalongkorn University Medical School, Bangkok, Thailand, 1967; interned St. Vincent's Medical Center Richmond, Staten Island, NY, one year; anesthesiology residency, Nassau County Medical Center, Long Island, NY, 1974-75; anesthesiology residency, Methodist Hospital, Brooklyn, NY, 1975-76; elected by Central Medical Society.

CONNER, MICHAEL G., Jackson. Born Birmingham, AL, Dec. 3, 1950; M.D., University of Alabama School of Medicine, Birmingham, 1976; interned University Medical Center, Jackson, MS, one year; pathology residency University of Alabama, Birmingham, 1977-80; fellowship, six months, same; elected by Central Medical Society.

LANEY, CHARLES H., Jackson. Born Greenwood, MS, Jan. 29, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University of Alabama, Birmingham, one year; internal medicine residency, same, 1976-78; nephrology fellowship, University of Texas at Southwestern, Dallas, 1978-80; elected by Central Medical Society.

MOODY, DAVID L., Madden. Born Fulton, MS, Jan. 24, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned, same, one year; elected by Central Medical Society.

WELCH, JERRY W., Laurel. Born Laurel, MS, Aug. 13, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Roanoke Memorial Hospital, Roanoke, VA, one year; ob-gyn residency, Louisiana State University Hospital and Charity Hospital, New Orleans, 1976-79; elected by South Mississippi Medical Society.

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Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

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PERSONALS

WILLIAM BATES of UMC presented a paper at a recent meeting of the American College of Obstetricians and Gynecologists in Las Vegas.

JIM BARNETT of Brookhaven has been named chairman of the State Board of Mental Health.

RICHARD C. BORONOW of Jackson presented a paper at the annual meeting of the Society of Surgical Oncology, Inc., in Boston.

A. WALLACE CONERLY of UMC was a site visitor for the Joint Review Committee for Respiratory Therapy Education in St. Petersburg, FL.

WILLIAM A. DAVIS announces the opening of his office for the practice of general medicine at Neshoba County Family Clinic in Philadelphia.

EDGAR DRAPER of UMC served as examiner for the American Board of Psychiatry and Neurology in Houston in April, spoke at the 12th annual Symposium on Medicine and Religion in Portsmouth, VA, and chaired a panel on clinical adaptive function of religion during a meeting of the American Psychiatric Association in New Orleans.

CARL EVERS of UMC attended the recent meeting of the Southern Group on Student Affairs, Association of American Medical Colleges, as president-elect.

LUTHER FISHER of UMC was consultant to the American Leprosy Mission in Belem, Brazil and Ascension, Paraguay, in April.

W. R. GILLIS of UMC spoke during the recent meeting of the Association of American Medical Colleges on St. Simon's Island, GA.

RICHARD T. GREEN announces the opening of his office for the practice of internal medicine at 921 6th Avenue in Picayune.

ARMIN HAERER of UMC presented a paper at the American Academy of Neurology meeting in Toronto.

JAMES HARDY of UMC presented a paper at a meeting of the American Association for Thoracic Surgery in Washington, DC, and delivered the Third John L. Madden Lecture in Hershey, PA, at the New York State Conjoined Surgical Symposium.

BRENT HARRISON of UMC presented a paper to the Keats Radiologic Society in Charlottesville, VA.

LEROY HOWELL of Starkville has been re-certified by the American Academy of Family Physicians.

JAMES HUGHES of UMC taught a course at the University of South Carolina in Greenville, SC, in April.

JOHN JACKSON of UMC spoke at a symposium on developmental disabilities at the Northwest Mississippi Retardation Center in Oxford.

HERBERT LANGFORD of UMC was in Birmingham, England, Paris, and Glasgow, Scotland as invited lecturer in April, was speaker at the National Conference on High Blood Pressure Control in New York, and lectured at the National Osteopathic Health Conference in Kansas City, MO.

MARK LEIFER has been accepted into membership by the American College of Physicians.

RODNEY MEEKS of UMC presented a paper at the Family Practice Geriatrics Conference in Columbus, GA.

FRANCIS MORRISON of UMC presented a paper at the South Central Association of Blood Banks meeting in Oklahoma City, OK.

NORMAN NELSON of UMC spoke to the New Orleans Chapter of the University of Mississippi Alumni Association in May and was in Baton Rouge as visiting professor during the annual spring meeting of the Earl K. Long Hospital staff.

WILLIAM B. PROFILET, JR. announces the opening of his office for the practice of obstetrics and gynecology at 116 East Academy Street in Canton.

DEATHS

MCLEAN, ROBERT BEATTY, Jackson. Born Memphis, TN, Mar, 3, 1905; M.D., Vanderbilt University School of Medicine, Nashville, 1928; interned Nashville Protestant Hospital and Charity Hospital, Nashville, 1926-28; surgery residency, New York City, 1928-31; Emeritus member of MSMA and AMA; died April 6, 1981, age 76.

STOWERS, KURTZ BISHOP, Natchez. Born Natchez, MS, Aug. 10, 1930; M.D., Johns Hopkins University School of Medicine, Baltimore, 1956; interned Grady Memorial Hospital, Atlanta, one year; surgery residency, same, 1957-61; died March 31, 1981, age 50.

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DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming.)

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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Concerns Cited At Conference on Aging

A lack of coordination among programs designed to assist the elderly was the main concern expressed at a recent statewide Conference on Aging in Jackson.

The meeting, which precedes a White House Conference on Aging to be conducted in Washington later this year, was attended by some 300 persons.

The "lack of coordination" theme was also expressed in a workshop on health care. Many participants agreed that something must be done to get government agencies providing health-related services to work together.

Responsibility for the health of senior citizens belongs to them and not a physician or a hospital, several participants said. The use of senior citizen multi-purpose centers for medical self-care workshops was one suggestion put forth to improve the health of senior citizens. Others suggested that rather than waiting until illness strikes, doctors and patients should together plan long-term comprehensive health programs.

Dr. David B. Wilson of Jackson served as coordinator of the Conference on Aging.

Major Change Made In Medicare Claim Processing

Medicare's allowable charge screens are updated on July 1 of each year based on charge data in the previous calendar year. In the past, the updated allowances were applied to all claims processed after the update. Effective July 1, 1981, "The Omnibus Reconciliation Act of 1980," (Public Law 96-499) requires that allowable charge determinations shall be based on profiles in effect on the date the service is *rendered* rather than the date the claim is *processed*.

Because of this change in pricing methodology, Travelers' Medicare recommends that claims and itemized bills with inclusive dates of service encompass only one calendar month per line billed.

The updated profile will be applied to charges for services rendered on July 1 and after. Charges for services rendered prior to July 1 will continue to be priced using the profiles in effect for the July 1, 1980 — June 30, 1981 profile year.

Hospital Designates Surgery Unit As Caldwell Memorial

The North Mississippi Medical Center in Tupelo has designated a new short-stay surgery unit in honor of the late Robert S. Caldwell, M.D. Dedication ceremonies for the 12-room unit were held May 24.

Dr. Caldwell, who was president-elect of the Mississippi State Medical Association at the time of his death in 1979, spent some 20 years in the practice of surgery in Tupelo.

Hospital spokesmen noted that the unit was built in an effort to hold down patient costs, as well as to free beds for patients who require more intensive care. Throughout his practice years, Dr. Caldwell was known to support new programs that would benefit both the patient and the physician.

The unit is operated by a registered nurse, a licensed practical nurse, and a ward secretary. Physicians make the final decision whether patients are candidates for the unit. The hospital reports that patient response to the short-stay unit has been very good.



114th Annual Session of MSMA

May 2-6, 1982

Biloxi Hilton, Biloxi

Mark Your Calendars Now!
And plan to be there for MSMA's big 125th anniversary.

PLACEMENT SERVICE

Physicians Wanted

ANESTHESIOLOGIST to join large community hospital. Contact Tom Askew, Administrator, Greenwood-Leflore County Hospital, Greenwood, MS 38930.

GENERAL PRACTICE opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

CLASSIFIED

FAMILY PHYSICIANS desperately needed to locate in West Central Alabama rural communities, one hour from Birmingham. Faculty appointment with Family Practice Center at University of Alabama if qualified. Join established practice or work individually. Salary of $42,000 to $55,000 guaranteed until practice is self-sufficient. Generous fringe benefits include life, disability, health, retirement, and malpractice insurance, two weeks continuing education, and three weeks annual leave. All equipment, including x-rays and lab, furniture, and supplies provided. Management services including personnel, payroll, tax reports, and billing provided. If invited to visit, all expenses will be paid. All moving expenses covered. Write Health Development Corporation, P.O. Box 1486, Tuscaloosa, AL 35403, or telephone Frank Cochran collect at 758-7545 for more information.

OBSTETRICIAN-GYNECOLOGIST to join 15-member multispecialty group, associated with JCAH-approved hospital. Associate partner status first year with guarantee plus percentage. No investment. Contact Karl Hatten, M.D., or H. Dean Andrews, Administrator, Vicksburg Clinic, Vicksburg, MS 39180.

CLAY ADAMS ELECTRONIC cell counter. Performs HGB, RBC, WBC; List $6,950.00 — sacrifice $3,500.00. Contact Robert T. Cates, M.D., (601) 856-6000.

ORTHOPEDIC SURGEON to join 15-member multispecialty group, associated with JCAH-approved hospital. Associate partner status first year with guarantee plus percentage. No investment. Contact Karl Hatten, M.D., or H. Dean Andrews, Administrator, Vicksburg Clinic, Vicksburg, MS 39180.

IMMEDIATE OPENINGS in Internal Medicine, Pediatrics, Family Practice and Industrial Medicine. Fifteen-member multispecialty group associated with JCAH-sponsored hospital. No investment. Contact Karl Hatten, M.D., or H. Dean Andrews, Administrator, Vicksburg Clinic, Vicksburg, MS 39180.

GYNECOLOGIST WANTED — for position with a women's medical facility located near New Orleans, LA. Our clinic offers first trimester pregnancy terminations and routine gyn care. Special training is available. Remuneration — excellent. A physician wishing to establish his/her practice would find the clinic most satisfying. Please send curriculum vitae to Medical Director, Metairie Women's Medical Center, 3008 19th Street, Metairie, LA 70002.

200 MILLIAMPS OFFICE X-RAY UNIT, complete with table, stand and new tube, and tank developing system, pig-o-stat, x-ray file storage, mobile screen, chest plate rack, apron and accessories. $8,000. Available now. Contact Dr. Lyle, Starkville Children's Clinic, P.O. Box 1507, Starkville, MS 39759; (601) 323-7510.

COMPHEALTH — Locum Tenens — Physicians covering physicians, nationwide, all specialties. We provide cost effective quality care. Call us day or night. T. C. Kolff, MD, President, CompHealth, 175 W. 200 S., Salt Lake City, Utah 84101, (801) 532-1200.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 114th Annual Session, May 2-6, 1982, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 29-August 1, 1981, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Howard Memorial Hospital
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

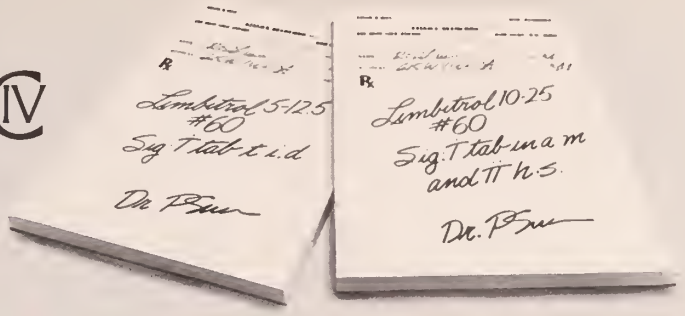
Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

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References: 1. Clagharn J: *Psychosamatics 11* 438-441, Sept-Oct 1970. **2.** Rickels K: Drug treatment of anxiety, in *Psychapharmacalagy in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crafts, 1977, p 316 **3.** Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychapharmacalagy: A Generatian af Pragress*, edited by Liptan MA, DiMascia A, Killam KF. New York, Raven Press, 1978, p 999

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use ot tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, contusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects ot both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dystunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

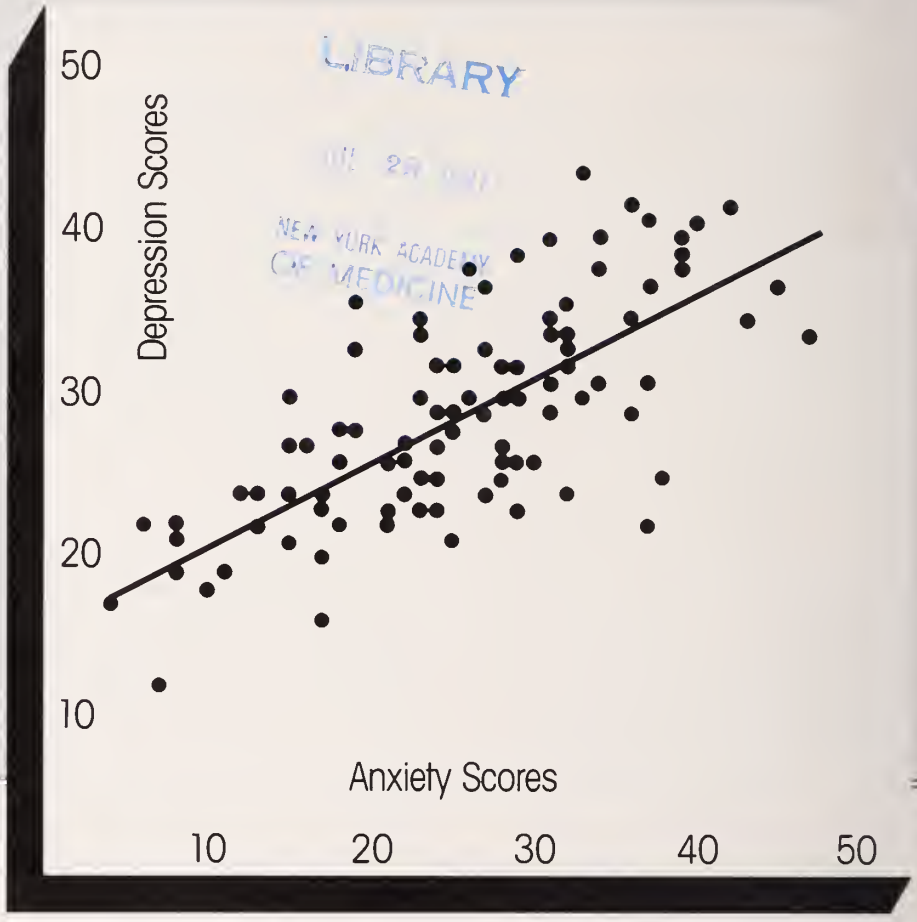
Limbitrol 10-25, initial dosage ot three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays ot 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50.

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MORE DEPRESSION MEANS MORE ANXIETY...



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The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.
—Adopted from Cloghorn J[1]

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Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

ROCHE®

1. Cloghorn J: *Psychosomatics* 11:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.

NEW YORK N.Y. 10029

August 1981

JOURNAL of the MISSISSIPPI State Medical Association



Mississippi's Maternal Mortality Rate

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/ Roche)®, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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Standard features on all Com Key systems include:

- Two distinctive tones that let you distinguish internal from external calls. If you're already on the phone, a muted verbal message or tone lets you know another call is standing by.
- Multi-line conferencing that can connect your business line with two or more outside lines.
- Line buttons that pop up automatically when you hang up to minimize the chance of someone inadvertently picking up during your conversation.
- Your choice of console faceplates, in colors or woodgrain, to complement office decor.

Optional features include:

- A ringing feature that keeps your phones working even if outside power fails.
- Paging systems that can broadcast messages to an entire office area or to specific departments. Or carry background music. (That same music can be piped into the system's "hold" function, for waiting callers.)
- A night transfer option (standard on the model 416) to connect after-hours incoming calls to any phone in your system.
- A privacy feature that keeps your conversations confidential when needed.
- Pre-set conferencing that will ring pre-selected combinations of phones simultaneously (a feature that could make lots of office memos obsolete).

Two more important considerations in any business phone decision: service and maintenance. At Bell, we take total responsibility.

So, before you choose a new office telephone system, call in a South Central Bell Account Executive at no extra cost. And get the total story on Com Key systems.

South Central Bell

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JOURNAL of the MISSISSIPPI State Medical Association

August 1981, Volume XXII, Number 8

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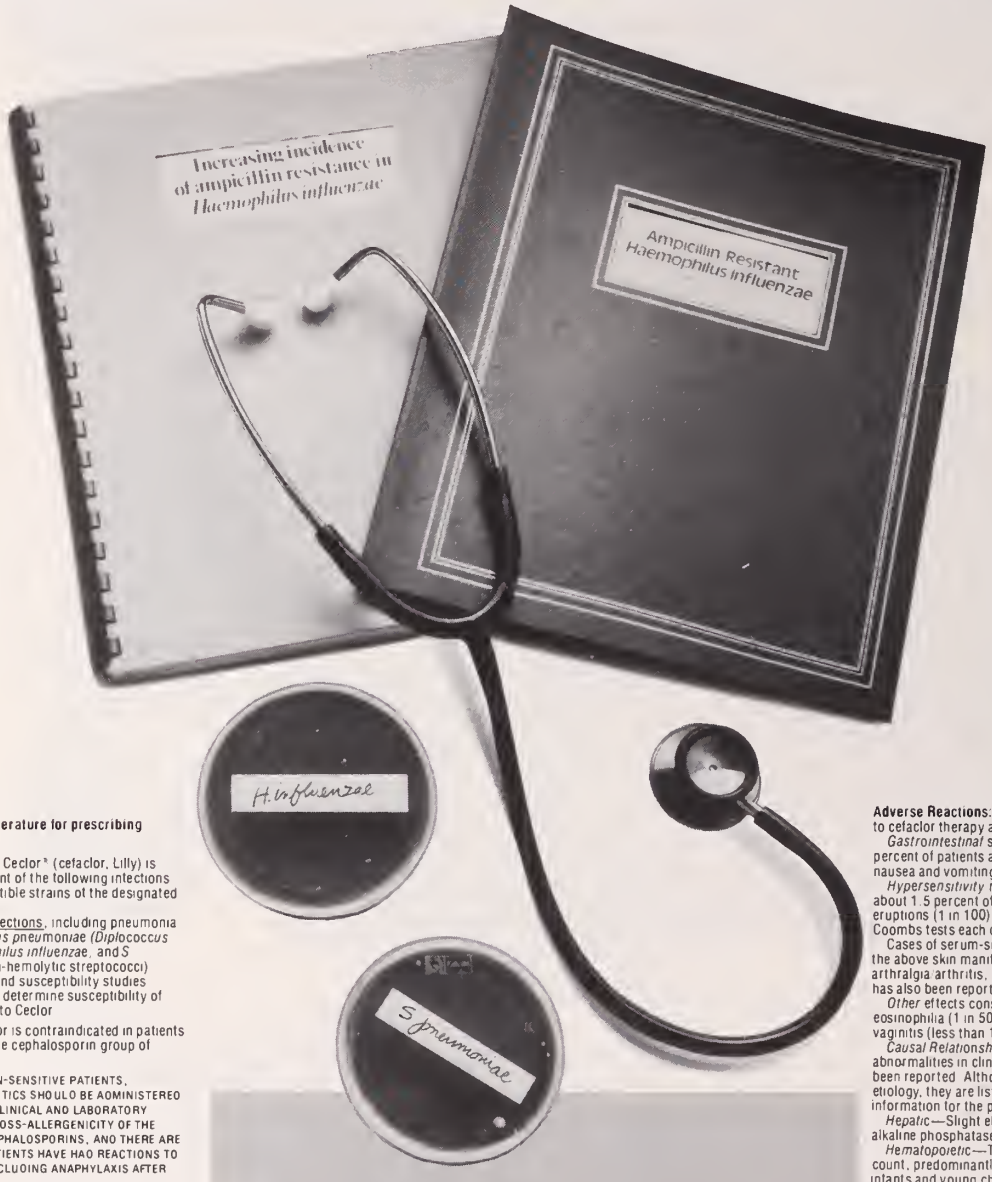
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(ISSN 0026-6396)

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975
2. Antimicrob. Agents Chemother., *11*:470, 1977
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

100061

Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia-arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[103080R]



PAIN AND TENSION...
Double fault for weekend warriors

ACE THE ACHE
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Equagesic®℠
(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

***INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified the indications as follows:
"Possibly" effective: for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e g alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION. An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e g caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, PA 19101



for mild to moderate pain

Wygesic®IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol tranquilizers, sedative-hypnotics or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts as well as misuse of tranquilizers, alcohol or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks (e g driving a car or operating machinery Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore propoxyphene should not be used in pregnant women unless in the judgement of the physician the potential benefits outweigh the possible hazards
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group
PRECAUTIONS: Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients some of these reactions may be alleviated if the patient lies down
Other adverse reactions include constipation abdominal pain skin rashes light-headedness headache weakness euphoria dysphoria and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported
DRUG INTERACTIONS: Propoxyphene in combination with alcohol tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
MANAGEMENT OF OVERDOSAGE SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume Cheyne-Stokes respiration, cyanosis) extreme somnolence progressing to stupor or coma pupillary constriction, and circulatory collapse In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported and apnea cardiac arrest and death have occurred
Symptoms of massive overdosage with acetaminophen may include nausea vomiting anorexia and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours However early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity aundice coagulation defects hypoglycemia encephalopathy coma and death may follow Renal failure due to tubular necrosis and myocardiopathy have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists naloxone nalorphine and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine which may cause anorexia nausea vomiting and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.

(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

NEWSLETTER

August 1981

Dear Doctor:

The Administration's mandate to improve regulatory procedures and provide relief from overly burdensome regulations was the topic of a detailed memorandum issued in June by Secretary Schweiker of the Dept. of HHS. He laid down six rulemaking principles to be applied when new rules are being contemplated or existing rules reviewed, and set a deadline of July 26 for his staff to submit written outlines of proposed regulatory goals for the next year.

> The six principles are: ensure that all regulations are clearly within legal authority; emphasize private market forces whenever possible; provide maximum flexibility to state and local governments; minimize costs; prevent fraud, abuse and waste; and eliminate rules not serving a compelling federal interest and reform other intrusive rules.

A presidential commission has endorsed the model state legislation on the determination of death previously adopted by the AMA, American Bar Assn., and the National Conference of Commissioners on Uniform State Laws. The president's commission urged all 50 states to adopt the model. So far, 27 states have adopted a definition, many with variations from the model.

Patient lists with itemized charges for the previous day were provided to physicians at Crawford Long Hospital in Atlanta under a hospital-wide cost containment program. Hospital spokesmen credit the innovation with nearly half of a total savings of $1,100,000 during 1979, by producing savings of about $3.25 per patient day, multiplied by 138,000 patient days.

A Maryland Appeals Court has ruled that a state agency, the Health Services Cost Review Commission (HSCRC), has no authority to regulate the fees of hospital-based radiologists who bill their patients directly. The case grew out of an original order by HSCRC that hospital-based radiologists, pathologists and cardiologists were subject to HSCRC review under its legislative mandate.

The December issue of Journal MSMA will be a special issue devoted to the association's 125th anniversary, which takes place December 15. The editors welcome any historical information or old pictures which might be useful in assembling this issue. Watch for more information about further activities for the celebration planned by a committee of past presidents.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

Urologic Education Series Presented to UMC

The University of Mississippi Medical Center's Division of Urology in the Department of Surgery has received a videotape system and 22 cassettes in a urologic education series, a gift from Norwich-Eaton Pharmaceuticals.

The video system and seven tapes have been on loan to the division since 1973. The company enlarged the series with 14 additional tapes in 1980, and made a gift of the entire system, with the final tapes, this year.

The newest tape features the films "Coagulum Pyelolithotomy" and "Surgical Anatomy of the Human Kidney and Its Applications." The first film received first prize at the 1980 American Urological Association annual meeting, and both films won Golden Eagle awards from the Council on International Nontheatrical Events.

Urology division chief Dr. Lamar Weems accepted for the Medical Center.

UMC Announces Faculty Promotions

Thirteen School of Medicine faculty members received promotions at the University of Mississippi Medical Center in July.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the changes in academic rank following approval by the Board of Trustees, State Institutions of Higher Learning.

Promoted to the rank of associate professor are Dr. Walter C. Kruckeberg, preventive medicine; Dr. Alan Freeland, surgery; Dr. Frank M. Wiygul, family medicine; Dr. Angel K. Markov, medicine; Dr. Jan Eric Jordan and Dr. Durisala Desaiah, neurology; Dr. Neil S. Whitworth, obstetrics and gynecology; and Dr. John E. Martin, psychiatry and human behavior.

Moving up to assistant professor are Dr. James Lu and Dr. Araya Chansanchai, medicine; Dr. John A. Fairbank, psychiatry and human behavior; Dr. Thomas H. Adair, physiology and biophysics; and Dr. John P. Naftel, anatomy.

Dr. Kruckeberg was postdoctoral fellow at the University of Michigan Medical School before joining the UMC faculty in 1978. A graduate of St. Olaf College, he earned the M.S. at St. Mary's College and the Ph.D. at Washington University.

Dr. Freeland holds the B.A. from Johns Hopkins and earned the M.D. at George Washington University. He interned at Church Home Hospital in Baltimore and took residencies at Johns Hopkins, Letterman Army Medical Center in San Francisco and at the Los Angeles Unit Shriners Hospital. He joined the UMC faculty in 1978.

Dr. Wiygul had been a member of UMC clinical faculty since 1956. Before joining the full-time family medicine faculty in 1979, he was chief of the Bureau of Family Health Services for the State Board of Health and medical director for Maternal and Child Health Crippled Children's Programs. An M.D. graduate of Harvard, Dr. Wiygul interned and took residency training at Charity Hospital in New Orleans and at Robert Green Hospital in San Antonio. He held a fellowship at Tulane University School of Medicine.

Dr. Markov, on the UMC faculty since 1975, earned the B.E.E. degree at the University of Sofia in Bulgaria and the M.D. at the Catholic University of Louvain, Belgium. Before completing residency and fellowship training at UMC, he was research associate at the University of Rochester, New Jersey College of Medicine and the Catholic University of Louvain. He also serves as director of cardiovascular research at UMC.

Dr. Jordan is a B.A. graduate of Albion College and earned the M.D. at Southwestern Medical School. He interned at Milwaukee County Hospital, took residency training at Walter Reed Army Medical Center and held fellowships at Duke University Medical Center and Durham Veterans Administration Hospital. Before joining the UMC faculty in 1977, he had been chief of the electroencephalography lab at Bexar County Hospital and the Audie Murphy VA Hospital in San Antonio since 1974.

Dr. Desaiah, a graduate of Government College in India, earned the M.Sc. and Ph.D. degrees at Osmania University. He held a postdoctoral fellowship at the University of Minnesota and was a research associate at Mississippi State and at the Medical Center before joining the UMC faculty in 1977.

Dr. Whitworth, on the faculty since 1976, earned the B.S. at San Diego State University and the Ph.D. at Rutgers. He held a fellowship at the University of Tennessee Center for the Health Sciences, was a research assistant at Scripps Clinic and Research Foundation and was on the Tennessee Health Sciences Center faculty before coming to UMC.

Dr. Martin, a graduate of Knox College, earned the M.A. at New Mexico State University and the Ph.D. at Auburn. He joined the UMC faculty in 1978 after completing a residency in clinical psychology at the Medical Center.

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine. Some of our better known products are Lopurin™ , Ru-Tuss® and Ru-Vert® . This advertisement highlights four other products particularly useful for the family.

F-E-P CREME® • SU-TON® • TWIN-K® • TWIN-K-CI™



For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin – Pramoxine HCl – Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (½ ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.





For Potassium Supplementation Improved Compliance...

TWIN-K®

Each 15 ml supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

The good tasting potassium supplement

- Designed for prophylactic and therapeutic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient dosage aid patient compliance.
  The organic salt of potassium can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine.[1]

1 Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, page 1959

In Cases with Chloride Deficiency...

TWIN-K-CI™

Each 15 ml supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride in a sorbitol and saccharin solution.

The good tasting potassium supplement with chloride

- In hypokalemic hypochloremic alkalosis, chloride ions are required. Twin-K-Cl is specially formulated to be a good tasting chloride containing potassium supplement.
- Contains no potassium chloride. Twin-K-Cl is a carefully balanced combination of organic potassium salts plus ammonium chloride.
- In hypochloremic patients, potassium should be provided as the chloride salt, or chloride ion must be made available in some other form, such as ammonium chloride or sodium chloride.[1]

See prescribing information on last page of this advertisement.



F-E-P CREME

DESCRIPTION

F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma, nuchal eczema and chronic eczematoid otitis externa, acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris corporis, pedis); moniliasis; intertrigo. Final classification of the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics

CONTRAINDICATIONS

Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella)

WARNINGS

This product is not for ophthalmic use.

In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY

Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS

F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period.

Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests. The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine.

Prolonged use of this drug may result in an overgrowth of non-susceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS

Skin rash or hypersensitivity may occur following topical application.

The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION

Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1 F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.

2 F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED

F-E-P Creme	½ ounce (15 gm) tubes	NDC 0524-0026-51
F-E-P Creme Plain	½ ounce (15 gm) tubes	NDC 0524-0025-51

Federal law prohibits dispensing without a prescription.

July 1980

SU-TON®

DESCRIPTION

Forty-five milliliters of SU-TON contain the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE

SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS

Epilepsy; convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS

The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS

Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS

Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE

Drug dependence has not been reported with SU-TON.

OVERDOSAGE

Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION

One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED

8ottles of 473 ml (16 fl oz) NDC 0524-0015-16

Federal law prohibits dispensing without prescription.

February 1980

TWIN-K®

DESCRIPTION

Each 15 milliliter (one tablespoonful) supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

INDICATIONS AND USAGE

For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS

Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS

TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation, it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS

Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS

Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE

The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes. Treatment measures include:

1 Elimination of potassium containing drugs or foods

2 Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters

3 Correction of acidosis

4 Use of exchange resins or peritoneal dialysis

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly

DOSAGE AND ADMINISTRATION

The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of potassium ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED

Bottles of 1 pint (16 fl oz) NDC 0524-0021-16

CAUTION

Federal law prohibits dispensing without prescription.

July 1980

TWIN-K-CI™

DESCRIPTION

Each 15 ml (one tablespoonful) supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride, in a sorbital and saccharin solution.

INDICATIONS

For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Potassium and chloride are usually the salts of choice in the treatment of hypokalemia since chloride and potassium deficiencies are likely to be associated with each other.

CONTRAINDICATIONS

Severe renal impairment with oliguna or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS

TWIN-K-CI is a palatable form of oral potassium replacement. Excessive, undiluted doses of TWIN-K-CI may cause a saline laxative effect.

To minimize gastrointestinal irritation, it is recommended that TWIN-K-CI be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS

Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K-CI is recommended for use in these patients.

ADVERSE REACTIONS

Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiograpic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K-CI taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE

The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly

DOSAGE AND ADMINISTRATION

The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 30 to 60 mEq of potassium ions and 8 to 16 mEq of chloride ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K-CI are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED Bottles of 1 pint (16 fl oz)

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DATELINE

ACP Responds To GMENAC Report

Philadelphia, PA - The American College of Physicians has released a comprehensive response to the final GMENAC report. The ACP Board of Regents noted that "the adequacy of health manpower, in terms of quality, numbers and distribution, is both a professional and societal responsibility." ACP called for joint participation by health professionals and government, but objected to additional legislation expanding government's authority in health manpower matters.

Alcorn Doctors Lead Funds Drive

Corinth, MS - Concern over a rise in the sudden death rate in Alcorn County during the first six months of the year has prompted the formation of a small coalition which aims to cut down the alarming rate. Three doctors and four private citizens are atttempting through private donations to raise funds to purchase telemetry equipment for installation in the county's EMS units. Dr. John W. Prather, a member of the group, estimates that up to 160 lives could be saved in a year.

Governor Favors Agency Merger

Jackson, MS - Governor Winter last month appointed four members of the Eleemosynary Board to vacant positions on the State Hospital Commission. The move was a step toward consolidation of the two agencies, an action which the governor favors as a way to save money and provide more effective operation of programs to provide care to poor patients. The parallel duties could be done through one office with existing personnel, it was reported. The merger requires legislative action.

Group Practices On the Increase

Chicago, IL - The number of group practices rose sharply in the 1970s - from 6,371 in 1969 to 10,762 in 1980, an increase of 69% - according to preliminary data compiled by the AMA's Division of Survey and Data Resources. During this same period the number of group physicians in the U.S. increased from 40,093 to 88,290, a rise of 120%. The biggest increase in group practices was reported in single specialty groups.

AMA Issues Drug Abuse Book

Chicago, IL - Drug Abuse: A Guide for the Primary Care Physician is a new AMA book designed to help physicians treat patients with drug problems. It deals with causes, incidence, diagnosis, treatment, and methods for confronting and counseling drug abusers and their families. Pointers are given on prescribing practices that curb abuse of prescription drugs. Single copies are available for $17 from the Order Dept., OP-323, AMA, P.O. Box 821, Monroe, WI 53566.

Dr. Brooks Honored at UMC



Dr. Thomas J. Brooks, left, who retired July 1 as professor of preventive medicine and chairman of the department at the University of Mississippi Medical Center, was honored for his contributions to the Medical Center at a luncheon at UMC. Dr. Brooks joined the School of Medicine faculty in Oxford in 1947 and was among faculty members who helped plan the health sciences campus and move the medical school to Jackson in 1955. Dr. Brooks has been a recipient of the Alan Gregg Fellowship in Medical Education and was a contributing editor to the 11th and 12th editions of Control of Communicable Diseases in Man. *Dr. Brooks' portrait will hang in the School of Medicine foyer. With Dr. Brooks are Mrs. Brooks and Dr. Norman C. Nelson, UMC vice chancellor.*

Davidsons Sponsor UMC Lecture



Among those attending the University of Mississippi Medical Center's 1981 ophthalmological conference were (from left) Dr. and Mrs. L. Stacy Davidson, Jr., and Dr. Samuel B. Johnson, UMC professor of surgery and director of the division of ophthalmology. The program was funded in part by the Dameron Friley Spruill and Willma Zay Spruill lectures in ophthalmology fund sponsored by Fay Spruill Davidson, Dr. Davidson, and their sons, John Stacy and Friley Spruill.

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
Otitis media caused by S. pneumoniae (formerly D. pneumoniae) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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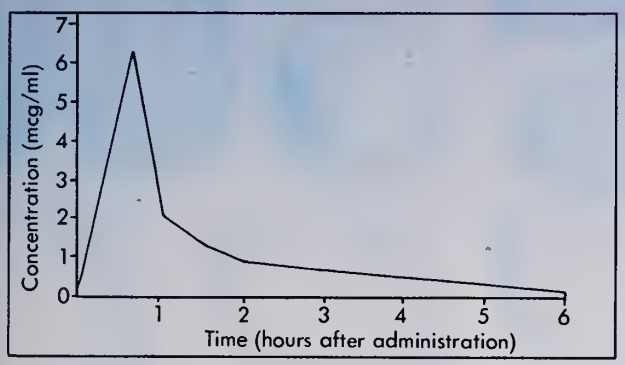
Half the dose is absorbed in 9 minutes!

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Less rash, less diarrhea than with ampicillin in studies to date.

Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
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- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

High Cure Rates with CYCLAPEN®-W (cyclacillin)		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumaniae	100% / 95%	73
Chronic Bronchitis† (acute exacerbatian)		
H. influenzae	92% — Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	12
Streptococcal Sore Throat†		
Graup A beta-hemolytic Streptococcus	100% / 86%	44
% Clinical Response % Bacterial Eradicatian		

†Due to susceptible orgonisms.

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CYCLAPEN®-W

(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

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See important information on facing page.

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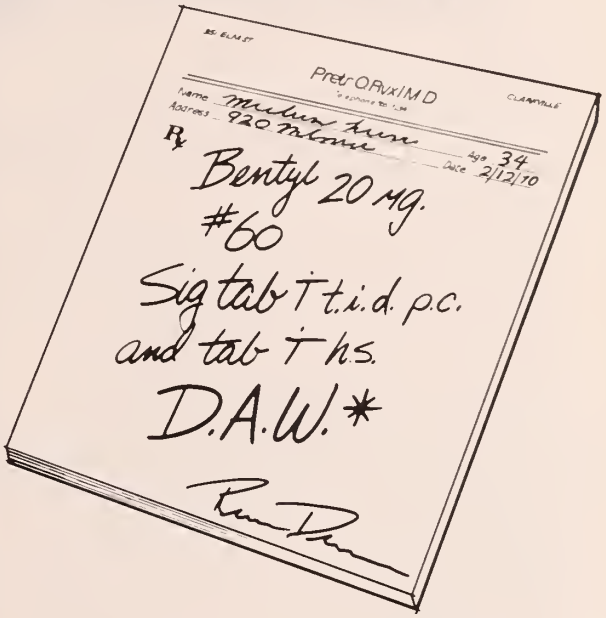
...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl®

(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



*D.A.W.-Dispense as written

because:

- The Bentyl molecule is a product of original Merrell research.
- At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- Significant pharmacologic effect in the distal colon compared to placebo,[1] shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:
1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics, antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention, blurred vision and tachycardia; palpitations; mydriasis, cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea, vomiting, impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*: 1 capsule or teaspoonful syrup three or four times daily. *Infants*: ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg. *Adults*: 1 tablet three or four times daily.

Bentyl Injection: *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
August 1981, Vol. XXII, No. 8

ORIGINAL PAPERS

Toxic-Shock Syndrome

MAX R. TAYLOR, M.D., and WILLIAM R. LOCKWOOD, M.D.
Jackson, Mississippi

Toxic-Shock Syndrome (TSS) is an illness that was first observed in older children by Todd et al in 1978.[1] After the initial report cases were recognized in adults, especially young menstruating women,[2] and in retrospect several of Todd's cases had presented during menses.[3] A case of TSS was recognized at the University of Mississippi Medical Center in November 1980. Although several publications stressed the problems encountered in TSS,[2, 4, 5] the management of hypotension in our case proved more difficult than anticipated. This report presents our observations and emphasizes the sudden occurrence of severe shock. In addition, the definition of TSS is reviewed and guidelines for management are suggested. The syndrome deserves the attention of physicians whose practice includes menstruating women.

Case Report

A 20-year-old nursing student was well until 10:00 PM when she noted discomfort in the muscles of her lower back. She presented to the emergency room at 4:00 AM with worsening muscle pain, fever, nausea, vomiting, and pharyngeal discomfort. There was no history of trauma, diarrhea, constipation, abdominal pain, dysuria, headache, or syncope. She was in the third day of her menses and Playtex super tampons had been used without interruption. This brand had been used during the three previous cycles without difficulty.

Her temperature was 102.1°F, and her blood pressure was 110/70 mm Hg in the supine position. Her pulse was 140 per minute, and her respirations were 14 per minute. Her weight was 51.4 kg. She was acutely but not severely ill. The conjunctivae were injected. The tonsils were enlarged and hyperemic and there was no exudate. The superior surface of the tongue was white with the papillae being prominent, giving the classic appearance of a "strawberry tongue." The posterior cervical lymph nodes were enlarged and tender, limiting forward flexion of the neck. The skin was diffusely erythematous except for pallor of the circumoral area. The skin creases of the antecubital area were erythematous and failed to blanch with pressure (Pastia's lines). The pelvic exam disclosed normal vaginal mucosa and an odorless, sanguineous discharge. There was no tampon material within the vagina, and further examination of the uterus and adnexa revealed no abnormality. The remainder of the physical exam was normal.

The hematocrit was 43%, the leukocyte count was 17,500/mm^3 with 12,250 neutrophils, 4,025 bands, 875 lymphocytes, 350 eosinophils, and the platelet count was 220,000/mm^3. A clean catch, centrifuged urine specimen contained 20-50 leukocytes per high power yield, and there was 2+ proteinuria. The chest roentgenogram was normal, and the electrocardiogram showed sinus tachycardia. Cultures of the urine and blood were sterile, and the culture from the throat grew normal flora. Cultures from the cervix and vagina later grew *Staphylococcus aureus*, resistant to penicillin. The titers of the streptozyme and Weil-Felix tests were not significantly elevated.

Although the house officers suspected that she had TSS, several hours elapsed before the appearance of a macular erythematous rash and a fall in her

From the Department of Internal Medicine, University of Mississippi School of Medicine, Jackson, MS.

blood pressure strengthened their suspicion. At 10:00 AM, 5 percent D5W was begun intravenously at 100 ml/hr, and nafcillin, 1.5 grams, was administered intravenously every four hours. Ten hours later the blood pressure fell to 70/30 mm Hg while she was supine. Two liters of 0.9 percent NaCl and 12.5 grams of albumin were infused over two hours. The blood pressure rose to 100/60 mm Hg but fell again to 70/30 mm Hg five hours later. Dopamine (6 mcg/kg/minute), 2.0 gram of methylprednisolone, 25.0 grams of albumin, and 0.9 percent NaCl were required to maintain the blood pressure during the next twelve hours (see Figure 1). After the initial 48 hours of therapy, her weight had increased 5.9 kg and the patient complained of tightness in the chest and extremities, which had become edematous. The chest roentgenogram revealed small, bilateral pleural effusions and no cardiomegaly. The electrocardiogram was normal. The hepatic, renal, metabolic, musculoskeletal, and hematologic abnormalities are depicted in Table 1.

She gradually improved over the next week, and subsequently the superficial layer of skin of the palms and soles desquamated. She has remained well.

Discussion

In May 1980 the Center for Disease Control (CDC) published the first report of the occurrence of TSS in menstruating women.[2] In June a report associated the illness with the use of tampons[4] and case definition criteria appeared in September (see Table 2).[5] Fever, hypotension, macular erythroderma, and involvement of three or more organ systems are the criteria utilized by the CDC to confirm a case as definite. Although these criteria were met by our patient, several hours elapsed before the rash appeared and the blood pressure fell, making the syndrome complete. The consequent delay in diagnosis emphasizes the nonspecificity of the early clinical findings which are seen in several diseases that enter into the differential diagnosis. These include scarlet fever, Rocky Mountain spotted fever, enteroviral exanthems, atypical measles, rubella, mononucleosis syndromes, dengue, meningococcemia, staphylococcal scalded-skin syndrome, idiopathic thrombocytopenic purpura, thrombotic thrombocytopenic purpura, systemic lupus erythematosus, Kawasaki syndrome, leptospirosis, and drug eruptions. Since the treatment of these conditions are quite varied, an error in diagnosis may lead to serious consequences.

In TSS 98% of cases occur during menses and there is a statistically significant association with the use of tampons, but cases do occur unassociated with menses or the use of tampons.[6] Surveillance studies suggest the incidence of TSS may be in excess of 3 per 100,000 menstruating women per year.[4] In Wisconsin, where the first intrastate surveillance studies of TSS were done, the incidence was 6.2 cases per 100,000 menstruating women per year and 8.8 cases per 100,000 menstruating tampon-users per year.[7] In Mississippi, eight cases were

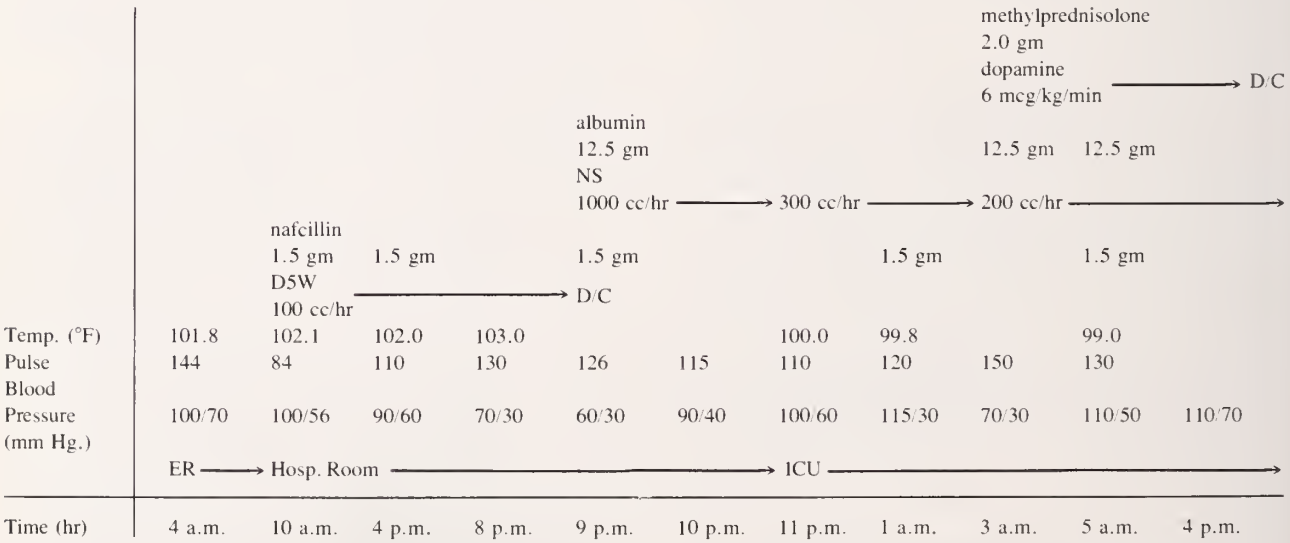


Figure 1. Clinical course during the first 36 hours after arrival in the emergency room.

TABLE 1
LABORATORY DATA

	Admission	*Day 1*	*Day 2*	*Day 3*	*Day 4*
SGOT (0-45 μ/L)	95	95	70	45	26
Bilirubin (.1-1.2 mg/dL)	.7	3.6	3.6	5.6	.9
BUN (10-25 mg/dL)	22	28	31	23	15
Creatinine (.5-1.7 mg/dL)	2.0	2.8	2.7	1.6	1.1
Bicarbonate (22-32 mEq/L)	18	14	18	21	29
Chloride (98-108 mEq/L)	106	113	117	115	104
CPK (0-225 μ/L)	405	448	567	505	106
WBC (5-10,000/mm^3)	17,500	22,900		14,000	
Platelet count (200,000-200,000/mm^3)	220,000	274,000		282,000	
Prothrombin time (same as control)		5 sec prolonged			
Partial thromboplastin time (same as control)		18 sec prolonged			

reported to the State Board of Health during 1980, and seven were classified as definite, satisfying the CDC criteria. The remaining case, in which there was no hypotension, was classified as probable. One death occurred as a consequence of refractory hypotension and disseminated intravascular coagulation. The case-fatality ratio reported by the CDC is 7.8%.[6]

Although the etiology of TSS is unknown, investigators have suggested that a toxin produced by *Staphylococcus aureus* may be responsible.[1, 7, 8] The organism has been recovered from the vagina in 97% of appropriately cultured cases, whereas only 10% of normal women carry it in the vagina during menses.[8] Isolates have also been recovered from the conjunctivae, pharynx, rectum, stool, and skin lesions. Despite the clinical features of fever and hypotension, organisms have not usually been isolated from the blood.[1, 8, 9]

Hypotension, one of the characteristic and potentially life-threatening events in TSS, varies in time of onset and in severity. It usually begins within 48 hours of the first symptoms and may not be noticed by the patient or may cause only minor dizziness. However, it may occur suddenly, resulting in syncope, or become severe and refractory, terminating in death. Intravascular volume depletion occurring as a consequence of capillary injury, insensible water loss associated with fever, fluid loss from diarrhea, and peripheral vascular vasodilatation are reasonable explanations for the occurrence of the hypotension. In our patient the hypotension was likely a consequence of insensible loss associated with sustained fever and capillary injury, which permitted an insidious decrease in intravascular volume that seemed disproportionate to her degree of illness and was not recognized until she became severely hypotensive. The process of capillary injury is reflected by the appearance of generalized edema and

TABLE 2
TOXIC SHOCK SYNDROME CASE DEFINITION[5]

1. Fever (temperature ≧ 38.9°C [102°F])
2. Rash (diffuse macular erythroderma)
3. Desquamation. One to two weeks after the onset of illness, particularly of palms and soles.
4. Hypotension (systolic blood pressure ≤ 90 mm Hg. for adults or < fifth percentile by age for children < 16 years of age, or orthostatic syncope).
5. Involvement of three or more of the following organ systems:
   A. Gastrointestinal (vomiting or diarrhea at onset of illness).
   B. Muscular (severe myalgia or CPK ≧ 2 × ULN*).
   C. Mucous membrane (vaginal, oropharyngeal, or conjunctival hyperemia).
   D. Renal (BUN or CR ≧ 2 × ULN or ≧ 5 WBC per HPF in absence of UTI).
   E. Hepatic (total bilirubin, SGOT, or SGPT ≧ 2 × ULN).
   F. Hematologic (platelets ≤ 100,000/mm^3).
   G. Central nervous system (disorientation or alteration of consciousness without focal neurologic signs when fever and hypotension are absent).
6. Negative results of the following tests, if obtained:
   A. Blood, throat, and CSF cultures.
   B. Serologic tests for RMSF, leptospirosis, or measles.

* ULN = upper limits of normal.

the 5.9 kg increase in weight which occurred after 48 hours of therapy. Although aggressive volume replacement (8-12 liters per day) and vasopressors have been recommended to maintain systemic blood pressure,[8] the situation may be complicated by myocarditis, renal insufficiency, and pulmonary capillary injury. In these situations invasive hemodynamic monitoring may prove helpful.

The management of TSS also includes removal of any retained tampon material and the administration of a beta-lactamase resistant antibiotic, since most isolates of *S. aureus* from cases of TSS are resistant to penicillin.[7, 8] The optimum dose or duration of antibiotic therapy is unknown; however, a 7-10 day course administered parenterally is usually effective in eradicating the organism and preventing recurrence, which has been documented in 30% of cases not treated with a beta-lactamase resistant antibiotic.[7] Although our patient was given glucocorticoids, there is no proof that they are of benefit in TSS.

Once recovered, the patient should avoid the use of tampons, because susceptibility to the disease appears increased for several months. A culture from the cervix and vagina should be obtained prior to the next menses. If *S. aureus* is isolated, therapy with an oral antibiotic resistant to beta-lactamase may prevent recurrence of TSS. All menstruating women may decrease the risk of developing TSS by avoiding the use of tampons or by changing them frequently when they are used.[6]

Summary

A history of gastrointestinal disturbance, myalgia, or syncope associated with fever in a woman necessitates inquiry of the menstrual history and use of tampons. Hypotension and macular erythroderma in this setting strongly suggests TSS. Severe shock may occur suddenly and require intensive medical care. All definite cases should be reported to the appropriate state health bureau. Suspected cases resulting in death should also be reported. In Mississippi, cases should be reported to the Disease Control Unit of the State Board of Health (364-6660).

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References

1. Todd, J., Fishaut, M., Kapral, F. and Welch, T.: Toxic-shock syndrome associated with phage-group-1 staphylococci. Lancet 2:1116-8, Nov. 25, 1978.
2. Epidemiologic notes and reports: Toxic-shock syndrome — United States. *Morbidity and Mortality Weekly Report,* CDC, 29:229-30, May 23, 1980.
3. Glasgow, L. A.: Staphylococcal infection in the toxic-shock syndrome. NEJM 303:1473-1475, Dec., 1980.
4. Epidemiologic notes and reports: Follow-up on toxic-shock syndrome. *Morbidity and Mortality Weekly Report,* CDC, 29:297-99, June 27, 1980.
5. Epidemiologic notes and reports: Follow-up on toxic-shock syndrome. *Morbidity and Mortality Weekly Report,* CDC, 29:441-45, Sept. 19, 1980.
6. Epidemiologic notes and reports: Toxic-shock syndrome — United States, 1970-1980. *Morbidity and Mortality Weekly Report,* CDC, 30:25-33, Jan. 31, 1981.
7. Davis, J. P., Chesney, P. J., Wand, P. J. and LaVenture, M.: Toxic-shock syndrome: Epidemiologic features, recurrence, risk factors, and prevention. NEJM 303:1429-35, Dec., 1980.
8. Shands, K. N., Schmid, G. O., Dan, B. B., Blum, D., Guidotti, R. J., Hargrett, N. T., Anderson, R. L., Hill, D. L., Broone, C. V., Band, J. D. and Fraser, D. W.: Toxic-shock syndrome in menstruating women: Association with tampon use and *Staphylococcus aureus* and clinical features in 52 cases. NEJM 303:1436-42, Dec., 1980.
9. McKenna, U. E., Meadows, J. A., Brewer, N. S., Wilson, W. R. and Perrault, J.: Toxic-shock syndrome, a newly recognized disease entity. Mayo Clin Proc 55:663-672, Nov., 1980.

The Continent Ileostomy

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THE CONTINENT ILEOSTOMY was introduced by Kock in 1969 and represents a tremendous contribution to the quality of life for the ileostomy patient.[1] It is composed of a pouch which is constructed from adjacent loops of ileum and a valve. The valve is created by intussuscepting the bowel upon itself. The pouch functions as a reservoir for storage of intestinal waste, while the valve prevents leakage (see Figure 1). Two to three times per 24 hours, the patient empties the pouch by introducing a catheter to allow drainage. It is not necessary to wear a bag. The stoma is covered by a small bandaid-size patch, during intervals between drainage.

Ileostomy Evolution

Great progress has been made since the days when ileostomy patients returned from surgery with a cross clamped segment of ileum protruding through the abdominal incision. Dr. Frank Lahey initiated the practice of moving the ileal stoma to a separate abdominal wall site.[2] The introduction of the Koenig-Rutzen bag, with its effective skin cement, represented a significant advance over previous appliances. These devices have been progressively improved over the years, and now many varied bags and accessories await the patient's choice.

It was a great advance in ileostomy management when Brooke devised the surgical technique for elevating the ileal stoma above the abdominal wall and folding it upon itself. This eliminated serosal exposure with subsequent serositis, which invariably resulted in stenosis and intestinal obstruction.

The lot of both patient and physician has been enormously influenced for the better by the appearance of a new category of allied health worker. The enterostomal therapist is a registered nurse who has pursued additional, special training in the field of ostomy management. Their advice, knowledge and support represent an invaluable contribution to patient care.

Indications

Total removal of the colon and rectum with the establishment of a permanent ileostomy may be necessary in patients with ulcerative colitis, granulomatous colitis and extensive colonic neoplasms, such as familial polyposis. The most common indication for coloproctectomy in patients with ulcerative colitis is intractability to medical management. These individuals may be incapacitated by diarrhea, weight loss, abdominal pain and weakness. Long term steroid therapy frequently results in troublesome side effects which merit concern. Malignant degeneration represents an ever-present threat, especially in patients who have had ulcerative colitis more than ten years. In younger patients, growth retardation may result from this disease. Systemic manifestations such as pyoderma gangrenosa, iritis, uveitis and arthritis may complicate the problem. Intestinal obstruction represents an indication for surgical intervention among ulcerative colitis patients. Toxic megacolon and hemorrhage may constitute indications for urgent surgical intervention.

Following coloproctectomy for granulomatous colitis, it is best to establish a conventional ileostomy. The threat of recurrent disease in the ileal pouch renders continent ileostomy an unattractive option.

The almost certain ultimate development of malignant degeneration among patients with familial polyposis of the colon supports the advisability of coloproctectomy. These patients represent acceptable candidates for construction of a continent ileostomy, because of the normal status of the ileum.

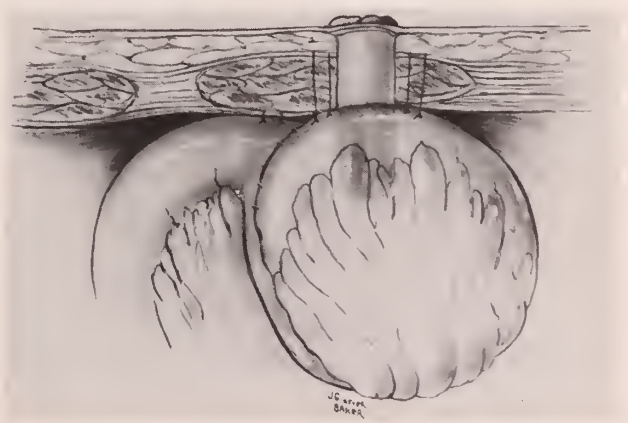


Figure 1. Continent ileal reservoir.

From the Department of Surgery, Mississippi Baptist Medical Center, Jackson, MS.

Construction

The reservoir is fashioned by sewing two 15cm loops of ileum together, opening them and folding the flat intestinal plate so as to form a pouch. It initially holds a volume of about 50cc, but over a period of months the capacity will increase to 600 to 1000cc. The valve is constructed by intussuscepting the efferent limb of ileum upon itself, so as to reside within the pouch. The terminal portion of the ileum is brought out through the abdominal wall and sewed flush with the skin surface (see Figures 2, 3). Through this stoma, the patient can introduce a catheter for drainage of intestinal content (see Figure 4). Our experience now includes nine patients in whom a continent ileostomy was constructed.



Figure 2. Skin level ileostomy stoma.



Figure 3. Small stoma is completely covered by a band-aid.

Postoperative Management

These patients require all the therapeutic measures commonly utilized after extensive abdominal surgery. Pulmonary care, parenteral fluids and antibiotics are administered. We are employing catheter gastrostomy in place of a nasogastric tube, and this materially contributes to patient comfort. The perineal wound must be followed closely so that problems can be detected early. Catheter drainage of the urinary bladder is usually employed for about seven days.

At the time of completion of the operation, a catheter is placed through the ileostomy stoma and into the pouch. The pouch is irrigated frequently, and low level suction is maintained. There is considerable evidence which suggests that this maneuver materially lessens the likelihood of valve slippage with later development of incontinence. Before being discharged from the hospital, the catheter is removed, and the patient is instructed in catherization of the pouch at regular intervals. This routine is mastered by the patient very rapidly.

It is important that the patient be instructed to avoid nuts, corn kernels and other particulate foods which may pose a problem with catheter obstruction. They should eat slowly and chew all food well.

Conversion of Conventional Ileostomy

Among the most grateful patients are those who sustained a conventional ileostomy initially and were later converted to the continent variety. They are better able to contrast the life style following each type of ileostomy. Most patients currently living with a conventional ileostomy are acceptable candidates for conversion. The procedure can be rather challenging because of occasional, extensive and dense adhesions, especially in the pelvic and sacral areas. Also, the small bowel, in its lower reaches, is usually edematous, thick walled and generally less pliable. In spite of these circumstances, a technically satisfactory valve and pouch can usually be achieved.



Figure 4. The pouch is easily emptied following insertion of a Foley catheter.

Possible Malfunctions

These patients are at risk to all of the occasional complications which may occur following extensive abdominal surgery. The major untoward development peculiar to the continent ileostomy patient is valve slippage and disinvagination of the intussuscepted ileum. Such a circumstance is suggested by leakage of intestinal content from the stoma and difficulty in catheterizing the pouch. The occurrence of this problem was reported to exceed 20 percent of patients in the Mayo Clinic series.[3] Goligher has also registered concern in regard to valve slippage.[3] Among our patients, this complication appeared in two of the first five cases. This led to some modifications in technique, among which are the current utilization of an isoperistaltic valve and the use of a marlex strip to reinforce the base of the valve. Five cases have been done according to the new technique, and leakage has not been observed thus far.

Diarrhea resulting from bacterial overgrowth has been observed in a small percentage of cases. It occurred in slightly over seven percent in the Mayo Clinic series.[3] The problem is satisfactorily managed by the administration of antibiotics effective against anaerobic organisms and gastrointestinal tract rest.

Suture line leakage represents a concern, in view of the extensive bowel edges which must be sewed. This problem was observed in one of our cases and necessitated removal of the pouch. The patient evidenced mesenteric panniculitis with enormous thickening and rigidity of the mesentery. There were also present many enlarged, hard lymph nodes. Folding over of the bowel plate to form the pouch could be achieved only by exerting great tension upon the suture line. Such a finding now would serve as a contraindication to pouch construction.

Advantages

With the continent ileostomy, a quality of life may be achieved which was never imagined to be possible for the coloproctectomy patient. Skin problems are virtually nonexistent, in contrast to conventional ileostomy, in which about 70 percent of patients are troubled by various skin abnormalities. There are no restrictions upon clothing. Bag-bulge, a necessary concern among conventional ileostomy patients, does not exist with the continent ileostomy. Because there is no need to wear a bag, continent ileostomy patients are spared the expense of purchasing these supplies and achieve a substantial savings, estimated to reach $700 to $1000 per year. With continent ileostomy, expulsion of bowel content is completely under the patient's control. Social and sexual anxieties are far less than those observed among conventional ileostomy patients. Disagreeable odors which may be associated with ileostomy appliances are eliminated.

Summary

Physiological conveniences, body image and the general quality of life can be enormously improved for the coloproctectomy patient by the construction of a continent ileostomy. The entire procedure can usually be completed during one operation. It is not necessary for these patients to wear a bag. A reservoir pouch with a valve is constructed from the terminal ileum, and this restores the capacity for storage of intestinal waste. Release of bowel content is completely under the patient's control. The pouch is usually emptied from two to three times per 24 hours. Earlier concerns in regard to valve slippage with resulting incontinence have been largely eliminated by recent modifications in the technique of valve construction. These improvements and the significant enhancement of the quality of life for these patients bring forth a need to reexamine the advisability of providing a Brooke type ileostomy in those cases favorable to the construction of a continent ileostomy. ★★★

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References

1. Kock, N. G.: Intra-abdominal reservoir in patients with permanent ileostomy. Arch. Surg. 99:223-231, 1969.
2. Turnbull, R. B. and Weakley, F. L.: Atlas of intestinal stomas. St. Louis, C. V. Mosby, 1967, p. 3.
3. Dozois, R. R., Keely, K. A., Beart, R. W. and Beahrs, O. H.: Improved results with continent ileostomy. Ann. Surg. 192:319-324, 1980.

The New Quack — Pseudoscience, Public Relations and Politics

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We live in an age of disillusionment. Public confidence in the institutions of our society has been shaken. That science and scientific medicine have not been spared this mistrust must surprise some when we reflect on the advances of these institutions over the past century. Yet on reflection, this very success has perhaps been one of the more significant factors in the genesis of many current problems. Much has been promised and much has been delivered, but science and medicine cannot deliver all. Rising expectations have spotlighted limitations; scientific and medical feet of clay have never been so visible. In this unsettling but understandable context, we now observe a most curious phenomenon: a resurgence of magical thinking and a popularity of pseudoscience which can only frustrate and bewilder those who had supposed that rational thinking and the scientific method had swept superstition into the cobwebbed recesses of some medieval alchemist's chambers.

Those who doubt the resurgence of magical thinking and pseudoscience need only switch on the television or glance over a paperback book display in the local drugstore. An astonishing variety of subjects including searches for ancient astronauts, abominable snowmen, inner powers which will change one's life, pyramid powers which will sharpen one's razors, Bermuda triangles, flying saucers, and so on ad nauseum are treated with deadly seriousness and are obviously of great popular interest. What is most striking, however, is the increasing sophistication with which such poppycock is presented. Much of this sophistication arises from a perversion of scientific thinking which may appropriately be termed pseudoscience. This rise in popularity of pseudoscience might simply be only good fun; but with a commercial instinct for the jugular which some elements in our society suggest is unique to physicians and oil companies, entrepreneurs of various sorts have sensed a profit potential previously available only from operations involving illegal gambling and drug sales. Were these commercialized pseudoscientific ventures confined to fairly harmless pursuits such as providing followers with a "mantra," little other than cash would be lost by the public. Caveat emptor. When, however, pseudoscientific cults begin to propose pseudoscientific solutions for serious medical or psychiatric problems, the stage is set for endless tragedy. In the spirit that one should know one's enemy, it will be the purpose of this paper to examine the methods of pseudoscience, to show how these methods are put into practice using the Laetrile cult as an example (although many others would serve equally well), and to offer suggestions as to how the medical profession can respond to the bizarre and disconcerting challenge which the pseudoscientists and their supporters present.

Science and Pseudoscience

Science is a systematic and rational method of thinking which has played no small part in the rise of Western civilization over the past several centuries. Within the past century the increasing incorporation of scientific methods into the art of medicine has produced tremendous advances in physicians' understanding of and ability to treat a variety of illnesses. This record certainly speaks for itself, and yet a simultaneous mistrust of science and scientific medicine has developed in the past ten to fifteen years and seems to be gaining strength. Even highly educated and intelligent people are not immune to these irrationalities. A variety of explanations have been advanced to explain the growing public disenchantment with science in general and scientific medicine in particular. These include increasingly hard to understand technology, increasing impersonality, increasing expense, and increasing expectations which have been generated by a combination of media exaggeration of medical advances and

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political declarations of the public "right to health care" which has been interpreted by many as the public's "right to health." The medical profession has not been completely innocent in the generation of these problems.

The explanation which has not received much attention, however, is the increasing tendency of purveyors of various questionable medical and psychiatric remedies to pervert the scientific method in a very sophisticated manner, which allows preposterous notions to be presented with an aura of scientific authority and respectability. The most obvious and familiar example is the television actor dressed in a white laboratory coat hawking some marginally worthwhile remedy for some trivial ailment to the vast TV audience. A "study" complete with graphs is often used to lend "scientific" weight to the commercial argument, and "experiments" with such technological marvels as the "nasograph" are performed. This commercial claptrap, repeated endlessly, must obviously cheapen the idea of the scientific process in the public's mind. Furthermore, a constant exposure to such trivial television experimentation in an atmosphere of authority and respectability may confuse the public as to what represents legitimate science and what does not.

Enter the pseudoscientist. To fully understand this process, a juxtaposition of the pseudoscientific method and the scientific method is necessary. The scientific method begins with observation and collection of phenomena. A hypothesis is then formulated to explain the phenomena, and experimentation is conducted to prove or disprove the hypothesis. Conclusions are then communicated to the scientist's peers, and these conclusions are confirmed or refuted. If the hypothesis is confirmed, it is then used to predict the outcome of phenomena explained by the hypothesis. In contrast, the pseudoscientific method begins with the formulation of a hypothesis. Supporting phenomena only are then collected, and the hypothesis is communicated through the mass media. The scientific "establishment" is then challenged to disprove the hypothesis, and those who try are accused of prejudice or conspiracy.

The most noteworthy difference in these two methods is the pseudoscientist's formulation of a hypothesis as a first step, probably reflecting the egalitarian notion that one's opinion is as good as anyone else's. "Facts" are then collected to support the hypothesis; those which contradict it are regularly ignored. Communication of the hypothesis via the mass communication media rather than to one's peers (who could confirm or refute the hypothesis independently) is a trademark of the pseudoscientist.

TABLE 1
A COMPARISON OF THE SCIENTIFIC AND THE PSEUDOSCIENTIFIC METHOD

Scientific Method	*Pseudoscientific Method*
1. Observation and collection of phenomena	1. Formulation of hypothesis
2. Formulation of hypothesis to explain phenomena	2. Collection of phenomena which appear to support hypothesis
3. Experimentation to prove or disprove hypothesis	3. Communication of hypothesis, usually in mass communications media
4. Communication of conclusions to peers, confirmation or refutation of conclusions by peers	4. Challenge scientific "establishment" to disprove hypothesis
5. Use of hypothesis to predict outcome of phenomena explained by hypothesis	5. Accuse those who try to refute hypothesis of prejudice or conspiracy

If identification of this trademark strikes uncomfortably close to home with respect to behavior by some more conventional scientists, including those in medical research, take warning. The key to the pseudoscientific process is to challenge the "establishment" to refute the pseudoscientific hypothesis. This represents a very neat reversal of the scientific method in which the onus of proof of the hypothesis is on the person who proposes it. The pseudoscientist simply demands that anyone who disagrees must refute his hypothesis and simultaneously saves a lot of time, money, and effort in experimentation which should rightly be his own responsibility. Understandably, the "establishment" may be somewhat reluctant to spend the time, money, and effort required to disprove every hypothesis, however preposterous, presented in such reputable media as certain sensational weekly "newspapers" or soft-core pornographic monthly magazines. This reluctance is beautifully played upon by the pseudoscientist who can then accuse the "establishment" of prejudice, or even better, of conspiracy to suppress his discovery, reaping further publicity and playing on the modern public's mistrust of "establishments" of any kind. A very neat and formidable strategy this is.

The Pseudoscience of Laetrile

The Laetrile cult presents a rich and varied paradigm to illustrate the workings of pseudoscience. The Laetrile cult is based on not one but two pseudoscientific hypotheses.

The first is the unitarian, or trophoblastic theory of carcinogenesis, first set forth by (the Scottish

physician) Dr. John Beard in 1902.[1] This hypothesis states that all cancer arises from embryonic rests of trophoblastic cells scattered throughout the body. In most people incipient cancers arising from these cells are destroyed by chymotrypsin. People who develop a cancer do so because of a lack of sufficient chymotrypsin caused by pancreatic insufficiency related to dietary inadequacies. This is an interesting conjecture which is totally contradicted by an overwhelming mass of data related to carcinogenesis collected over the past 50-100 years and, in modern times, is so absurd as to not merit even a passing effort at refutation by the scientific community.

The second hypothesis is, on the surface, somewhat more plausible. Ernest T. Krebs, in 1920, with modifications in the 1950's by his son E. T. Krebs, Jr., proposed that cancer cells contain more of the enzyme β-glucuronidase than normal cells. Therefore, cancer cells should be vulnerable to chemotherapy with the organo-cyanide composed *Lae*vorotatory mandelon*itrile* or Laetrile obtained from the compound amygdalin, which occurs naturally in kernels of peaches, apricots, bitter almonds, and apple seeds.[2] Laetrile presumably undergoes the following reaction in cells rich in β-glucuronidase: Laetrile → glucose + benzaldehyde + HCN. The liberated HCN destroys the tumor cell. Normal cells, according to this theory, not only have less β-glucuronidase (and therefore are less susceptible) but also are protected because they contain the enzyme rhodonase which inactivates HCN. Cancer cells allegedly lack rhodanase. This is a complicated notion which has, under the pressure of continued claims by the Laetrile pseudoscientists, been evaluated, albeit reluctantly, by the "establishment." The Laetrile proponents, in the finest pseudoscientific spirit, have barely made the slightest effort to provide evidence on their own. The biochemical rationale for the alleged effectiveness of Laetrile has been categorically refuted by a number of studies.[3, 4] It has been shown that normal cells, if anything, contain more β-glucuronidase than tumor cells and that there is no particular difference in the content of rhodanase contained in tumor or in normal cells. Furthermore, a succession of animal and clinical human tests have failed to show the slightest antitumor effect of Laetrile, whether given orally, intravenously, or with or without β-glucuronidase.

The time and expense of these multiple studies over a period of 20 to 30 years is obviously considerable, and one could wonder whether the efforts involved in such studies might not have been employed more productively elsewhere. What is most remarkable, however, is that despite this weight of negative evidence as to the worth of Laetrile as an anticancer drug, the public clamor in support of Laetrile persists and has, if anything, intensified. The reason is that the pseudoscientist does not play the scientific game, as we shall examine. No amount of scientific data will ever convince the pseudoscientists and their supporters. If the pseudoscientists *were* to play the scientific game, they would have abandoned Laetrile long ago. With a strong profit motive involved, however, the Laetrile pseudoscientists have struck off into new territory.

TABLE 2
ANIMAL AND HUMAN STUDIES OF THE ANTITUMOR EFFECT OF LAETRILE

Date	*Test System*	*Result*
	Animal	
1975	Transplantable Mouse Tumor	No Activity
1975	Transplantable Rodent Tumor	No Activity
1978	Transplantable Animal Tumors	No Activity
1978	Spontaneous Animal Tumor	No Activity
1978	Nude Mouse-Human Tumor Transplant	No Activity
	Clinical	
1953	Clinical Review 44 pts Calif. Med. Assoc.	No Activity
1965	Clinical Review Canada Med. Assoc.	No Activity
1978	Clinical Review National Cancer Inst.	No Definite Support for Activity

Pseudoscientific Gamesmanship

The pseudoscientist often provokes the scientific establishment into attacks on and refutations of his particular brand of pseudoscientific dogma, as in the case of Laetrile discussed above. This occurs when the particular pseudoscientific dogma is perceived by the establishment (often with good cause) as a psychological or physical threat to society, particularly when large sums of money begin to be made by the pseudoscientist and supporters (as often occurs). The astute pseudoscientist will not be deterred by these attacks, even when the evidence refuting his hypothesis appears overwhelming. Unlike the scientist, who is constrained by the necessity to have experimental data to support his hypothesis, the pseudoscientist can change or modify the pseudoscientific hypothesis at will to deflect or circumvent criticism or even to take advantage of loopholes in whatever laws may be involved to control commercialization of this pseudoscientific venture.

This shifting of philosophy is usually accompanied by complaints of "persecution by the establishment." A common and effective pseudoscientific practice is to denounce data produced by the scientific establishment which refute the pseudoscientific hypothesis on the grounds that such data were collected by prejudiced individuals and therefore are suspect. The symmetry is beautiful! The pseudoscientist refuses to produce supporting data, and no one else is allowed to do so because they are prejudiced and conspiring to suppress the pseudoscientific hypothesis.

In the unusual circumstances that data is produced by the pseudoscientist, either in support of the original hypothesis under attack or in support of one of the newer "clone" hypotheses, the data almost always is in the form of testimonials and anecdotes. If the pseudoscientists can recruit as a believer some sort of celebrity who will lend his name to testimonials, this is especially desirable. Strange as it may seem, such celebrities may occasionally be defectors from the "establishment" who abandon their dedication to science for a variety of reasons, not the least of which is the outpouring of publicity which commonly attends such a move.

Gamesmanship of the Laetrile Cult

Laetrile was originally offered as a cure for cancer on the basis of the hypotheses discussed earlier. It soon became apparent that cancer patients were not cured by Laetrile, so Laetrile suddenly became a control for cancer. When studies and observations cast some doubt on this position, Laetrile then came to its present designation as a cancer preventive and a drug which "makes patients feel better."

When Laetrile was denied Federal Drug Administration (FDA) licensing as a new drug, Laetrile suddenly became a vitamin and therefore presumably exempt from FDA regulation. The federal courts were not impressed by these semantic games. Rumors were circulated that cancer is virtually unknown in certain remote cultures such as the Hunzas in the Himalayas who eat a diet which includes apricot pits. This was presented to the faithful as evidence that Laetrile is indeed a vitamin. The idea is simply not true, as anyone who has troubled to study the Hunzas could testify.[5]

Undeterred, the Laetrile supporters, in a masterful amalgamation of modern pseudoscientific dogma, now declare that Laetrile must be used in combination with a natural organic dietary program in a "holistic" program in order to be fully effective. This brilliant strategy has the advantage of playing on the current health food fad while at the same time increasing the already considerable revenue extracted from cancer patients under Laetrile "therapy."

Now faced with a "vitamin" which prevents cancer or, if it doesn't, makes cancer patients "feel better," but is only effective when used with a "holistic" program of organic food diets, other vitamins, and further variations such as coffee enemas, the scientific establishment can hardly be blamed if it blanches at the prospect of disproving these claims.

Pseudoscience and Politics

The word "cult" is appropriately applied to pseudoscientific hypotheses and their believers and supporters. At a certain stage of development, most pseudoscientific movements begin to take on the trappings of religion. In any case, organization of supporters occurs; and these organizations are used to recruit more followers, to take advantage of tax laws, and to obtain respectability by political fiat rather than by the inherent merit of their philosophy.

This behavior is easily recognized in religious cults where the leader is a "Reverend," a "Guru" or a "Maharishi," where the organization is a tax-exempt religious institution, and where respectability is sought on the grounds of freedom of religion. The pseudoscientific cult is somewhat more subtle, but the behavior remains the same. Instead of a religious title, the leader of pseudoscientific cult is a "scientist" or a "doctor" who may or may not have

TABLE 3
ORGANIZATIONS SUPPORTING LAETRILE

Organization	*Comment*
John Beard Memorial Foundation	Ernest T. Krebs, Jr., President
McNaughton Foundation	Distributes Laetrile "Literature"
	Distributes Laetrile
International Association of Cancer Victims and Friends	Political Lobbying Group
Cancer Control Society	Political Lobbying Group
Committee for Freedom of Choice in Cancer Treatment	Political Lobbying Group

a degree which may or may not be relevant to the area of alleged scientific competence. Instead of a religious tax exemption, the pseudoscientific cult will have one or more non-profit (read tax-exempt) "foundations" which will serve to promote the pseudoscientific dogma and to provide a handy parking place for funds, the accumulation of which tends to become considerable as the organization grows.

The pseudoscientific cult craves respectability. Since it is hardly likely that respectability will be granted on the basis of scientific merit, supporters and "foundations" are often involved to a great extent in seeking judicial and/or political recognition which will lead to the granting of scientific respect by fiat. The patience of a cult is apparently limitless (after all, there are considerable financial rewards to be obtained). The patience of the establishment is, of course, limited, and the financial incentives in pseudoscientific cult fighting are entirely negative. If the establishment hopes the pseudoscientific cult will simply go away if ignored, the establishment is sadly mistaken.

Laetrile and Politics

Over the years, the Laetrile cult has collected a number of supporting organizations and "foundations" including the John Beard Memorial Foundation, McNaughton Foundation, International Association of Cancer Victims and Friends, Cancer Control Society, and Committee for Freedom of Choice in Cancer Treatment. In addition to publishing and distributing literature (often in the form of comic books which savagely attack conventional medicine) and otherwise maintaining interest in Laetrile, the major thrust of these organizations in past years has been legal and political maneuvering. These efforts have centered around the issues of privacy and freedom of choice.

This has proved to be a most effective strategy. On the surface, who is really against a person's right to privacy and to freedom of choice as to what treatment he receives for an illness? The suggestion is that the federal government and conventional medicine are conspiring to restrict patients' freedom of choice in their therapy. This accusation bears examination. In our present system (although some fear not for much longer) a person is free to select his own doctor. He is free to seek other opinions. He is free to accept or reject treatment proposed by any of these doctors. There would seem to be considerable freedom of choice in this system, so the question then becomes how much freedom is desirable? If the public has a right to complete freedom of choice regarding medicine, the FDA and medical schools can be done away with, and anyone who wishes would be free to "practice" medicine in any way they wish. Few would agree that such a degree of freedom is wise, because another right of the public would then be in danger: the right to have confidence in a certain standard of competence of the physicians consulted and a right to expect that proposed therapies have a reasonable chance of success. In other words, the public has a right to an *informed* free choice of therapy. The track record of pseudoscientific cults in general, and the Laetrile cult in particular, in providing a balanced and unbiased position upon which an informed choice may be made has been less than exemplary for reasons which by this time must seem all too obvious.

Despite these considerations, the Laetrile cult and its supporters and "foundations" have succeeded in persuading several state legislatures to pass laws allowing treatment of "terminal" cancer patients with Laetrile. To be sure, a variety of restrictions are included in these laws; and, to be sure, the FDA is still capable of preventing importation or interstate shipment of Laetrile. Nevertheless, the emotional response of certain state legislatures, in total disregard of the vast body of evidence attesting to the complete worthlessness of Laetrile as a cancer therapy, cannot have any effect other than to encourage the continued perpetration of the Laetrile fraud on the American public. One cannot help wondering what would happen if a cliffjumping cult could gather enough supporters to apply the kind of political pressure that Laetrile supporters have done. Presumably, a number of state legislatures could be persuaded to repeal the law of gravity.

Pseudoscience and the Medical Profession

Given the formidable attack on many fronts with increasingly sophisticated techniques of deception

by various pseudoscientific cults, the busy physician might be inclined to take the position of H. L. Mencken, who suggested that medical cultism was beneficial to the human race, as those foolish enough to prefer such self-destructive "therapy" would soon be eliminated from society permanently. On reflection, however, this position is unacceptably harsh, especially when victims of pseudoscientific cults are deliberately deceived by these cults and their supporters.

It is true that a number of pseudoscientific cults do little harm other than to extract money from their followers. No one has yet been injured by "pyramid power" unless one's razor blades become dangerously sharp. It is when pseudoscientific cults propose useless and dangerous therapies for dangerous diseases that the medical profession should rightly become concerned. In the case of Laetrile, not only may the cancer patient's reliance on Laetrile lead to delay or omission of potentially helpful or even curative conventional treatments, but Laetrile therapy itself has potential for direct harm. The claims of Laetrile supporters that Laetrile is "nontoxic" have now been thoroughly refuted by a number of documented fatal cyanide poisonings from Laetrile ingestion.[6-7] There are probably a far greater number of cases of chronic cyanide poisoning caused by Laetrile, but few have been reported because this diagnosis is so difficult to make.[8, 9, 10]

If eternal vigilance is the price of liberty, it is also the price which scientific medicine must pay to deliver the best possible care to the public. However tiresome and frustrating the fight may become, continued efforts to alert and educate the public must be made. A great deal of patience and compassion is needed in this struggle, and these are qualities which scientific medicine has not always fostered. It may be trite to remember that medicine, however strong the scientific foundation, remains an art. If the art of medicine is neglected by the scientist and pursued only by the pseudoscientific huckster, the future of rational scientific medicine will be bleak. Therefore, practitioners of scientific medicine must be scientifically objective about their therapies while at the same time maintaining a relationship of trust and confidence with their patients so that these people will not be placed in desperate positions in which they become susceptible to emotionally based hucksterism.

Scientific medicine must also continue to publicize its views and not hesitate to identify fraud and quackery for what it is wherever and whenever it appears . . . and it will. This is a battle which will never be over, but the public welfare demands and deserves the unflagging efforts of us all.

Note: At the May 1981 meeting of the American Society of Clinical Oncology, the Mayo Clinic, in collaboration with three other institutions, reported the results of the use of Laetrile in human cancer victims. This trial, forced by pseudoscientific pressure, showed no evidence of significant activity for Laetrile in the treatment of human neoplasms. ★★★

2500 North State Street (39216)

References

1. Beard, H. H.: A new approach to the conquest of cancer, rheumatic and heart disease. New York, Pageant Press, Inc., 1958. 2nd edition, paperback, 1962.
2. Unproven methods of cancer management. Pg. 140. The American Cancer Society, Inc. 219 E 42nd Street, New York, NY 10017.
3. Dorr, R. T. and Paxions, J.: The current status of Laetrile. Ann. Int. Med. 89:389-397, 1978.
4. Greenburg, D.: The case against Laetrile. Cancer 45:799-807, 1980.
5. Harada, N. and Myoshi, A.: Is the healthy Hunza true? Results of the Kyoto University Scientific Expedition to the Karakoram and Hindukush, 1955. Vol. 5, 1-14, 1963.
6. Braico, K. T., Humbert, H. R., Terplan, K. L. et al: Laetrile intoxication: Report of a fatal case. NEJM 300:238-240, 1979.
7. Sadoff, L., Kaspar, F. and Hollander, J.: Rapid death associated with Laetrile ingestion. JAMA 239:1532, 1978.
8. Ortega, J. and Creek, J. E.: Acute cyanide poisoning following administration of Laetrile enemas. J. Pediatr. 93:1059, 1978.
9. Smith, R. P., Butler, T. P., Cohan, S. et al: Laetrile toxicity: A report of two cases. JAMA 238:1361, 1977.
10. Morse, D. L., Harrington, J. M. and Heath, C. W., Jr.: Laetrile, apricot pits, and cyanide poisoning. NEJM 295:1264, 1976.

Maternal Mortality in Mississippi: 1977-1978

WILLIAM B. WIENER, M.D.
Jackson, Mississippi

In 1957, the Mississippi State Medical Association (MSMA) established a committee to study, as a continuing research and educational program, the maternal mortality cases occurring each year in the state of Mississippi. The study has emphasized education directed at improved maternal care and has received the support of the medical profession in our state. The Committee on Maternal and Child Care recently completed its study data for the calendar years 1977-78.

Death certificates from the Mississippi State Board of Health furnished to the committee indicate that there were 8 and 7 maternal deaths in Mississippi in 1977 and 1978, respectively. The number of live births to Mississippi residents (in state and out of state) totalled 45,532 in 1977 and 44,373 in 1978.

The maternal mortality rate for Mississippi residents (maternal deaths per 100,000 live births) was 22.0 in 1977 and 13.5 in 1978. The maternal mortality rates for the United States in 1977 and 1978 were 11.2 and 9.6, respectively.

It is significant to note the decline in maternal mortality in the state since the Committee on Maternal and Child Care began its study in 1957. In that year, there were 75 maternal deaths and the state's maternal mortality rate was 120. As noted, in 1978 there were 7 deaths, and the rate was 13.5 per 100,000. This decline is due to many factors, perhaps the most significant of which are: increased specialization in ob-gyn; improved hospital and transportation systems; improved referral and consultative services provided by the creation of the University of Mississippi School of Medicine; and the establishment of family planning clinics providing contraceptive education and the legalization of abortion under medical supervision, both of which have resulted in fewer high risk pregnancies.

Techniques of obtaining and reviewing information on maternal deaths have not changed appreciably during the 22 years of study. The questionnaire type of inquiry has been exclusively employed. No "on the spot" investigations of hospital records or interviews of physicians or hospital personnel have been conducted except under rare circumstances involving hospitals in Jackson. The data sheet used was developed by the committee before the study began and has undergone only minor changes since then. One of the data sheets, together with a letter from the chairman of the committee, is sent to the physician who last attended the patient. He or she is asked to complete and return the data sheet and add any pertinent information in a supplementary note. If the physician does not reply, two followup letters are sent at appropriate intervals. In some cases, personal attempts have been made by members of the committee, the State Board of Health, officers of the association, or local obstetricians to obtain information. Letters requesting additional information occasionally have been sent to the responding physician by the committee, if it seemed likely that he could supply further information which might be of value.

Following receipt of the data sheet and other information, all identifying marks are removed so that anonymity is preserved. A copy of the data sheet is then sent to a member of the committee for review prior to the next meeting. At the meeting of the committee, the case is summarized by the member who has studied and evaluated it according to the criteria set out in the AMA "Guide for Maternal Death Studies." The evaluations are discussed by the committee, agreed to or voted on if there is a division of opinion, and then furnished to the attending physician.

Chairman, Committee on Maternal and Child Care.
Committee members — William B. Wiener, M.D., Jackson; W. E. Godfrey, M.D., Natchez; John C. Morrison, M.D., Jackson; George J. Nassar, M.D., Greenwood; K. Ramsay O'Neal, M.D., Hattiesburg; Wendell H. Stockton, M.D., Amory; W. W. Walley, M.D., Waynesboro.

The committee studied 15 maternal deaths occurring in 1977 and 1978. All replies to the committee's inquiries are evaluated as to their usability (see Table I) and usable replies are classified according to the adequacy of the data furnished (see Table II). In order to receive the highest rating, which is 5, the questionnaire for the committee's study must be completely filled out, a relevant explanatory note attached, and an autopsy report included if available. Cases rate 1 or 2 are often difficult to evaluate because of gaps in data received.

Following the AMA "Guide for Maternal Death Studies," the committee classifies maternal deaths as either being direct obstetric deaths or indirect obstetric deaths. Direct obstetric deaths are defined by the guide as those in which the cause of death is due to a condition directly related to the pregnancy such as hemorrhage, toxemia, infection, anesthesia or vascular disease. Indirect obstetric deaths are those resulting from disease which was present before or developing during pregnancy but was obviously aggravated by the physiological effects of the pregnancy and caused the death. Classification of maternal deaths studied by the committee in 1977 and 1978 as to direct or indirect deaths is shown in Table III.

The direct obstetric deaths studied by the committee have also been classified as to cause in Table IV. As noted therein, hemorrhage and toxemia accounted for 6 of the 10 direct obstetrical deaths occurring in 1977 and 1978. Table V presents the information for each year of the committee's study thus far (1957-1978).

TABLE I
STUDY MATERIAL

	1977		1978	
	No.	*Percent*	*No.*	*Percent*
Total Cases	8		7	
Replies received	8	100	7	100
Replies usable	8	100	7	100

TABLE II
ADEQUACY OF DATA

	1977		1978	
Category	*No.*	*Percent*	*No.*	*Percent*
5	1	12.5	2	28.5
4	2	25.0	2	28.5
3	3	0	0	0
2	2	25.0	3	42.8
1	0	38.0	0	0

TABLE III
CAUSES OF DEATH

	1977		1978	
	No.	*Percent*	*No.*	*Percent*
Direct	5	62.5	5	71.4
Indirect	3	37.5	2	28.6
Undetermined	0		0	

TABLE IV
CAUSES OF DIRECT OBSTETRIC DEATHS

	1977		1978	
	No.	*Percent (of All Deaths Studied)*	*No.*	*Percent (of All Deaths Studied)*
Hemorrhage	3	37.5	3	44.4
Toxemia	0		1	14.4
Infection	0			
Vascular accident	1	12.5		
Anesthesia	2	25.0	1	14.4

TABLE V
CAUSES OF DIRECT OBSTETRIC DEATHS (1957-1978)

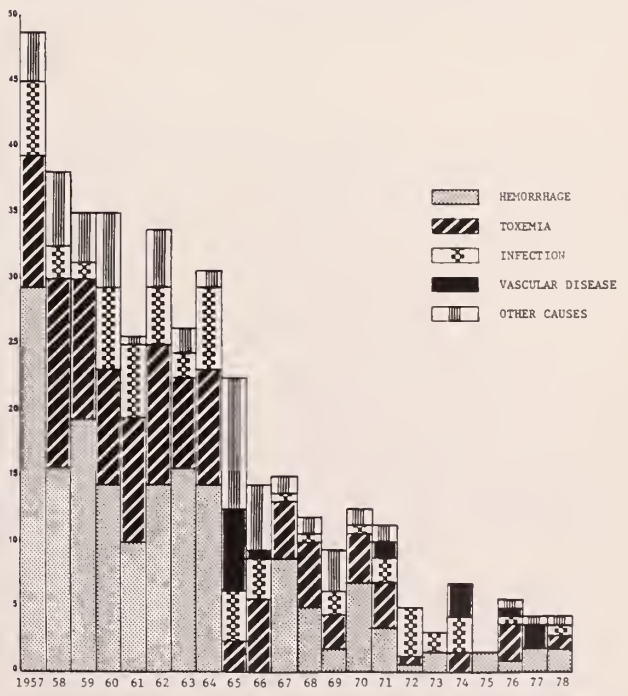


TABLE VI
AVOIDABILITY

	1977		1978	
	No.	*Percent*	*No.*	*Percent*
Avoidable	5	62.4	5	71.4
Non-avoidable	1	12.5	1	14.4
Undetermined	2	25.0	1	14.4

TABLE VII
AVOIDABLE FACTORS

	1977		1978	
	No.	*Percent*	*No.*	*Percent*
Professional	5	62.5	5	71.4
Hospital	1	12.5	0	
Patient	0		0	
Undetermined	2	25.0	1	14.4

Again, following the AMA "Guide for Maternal Death Studies," the committee determines the avoidability of those maternal deaths studied (see Table VI). Avoidability is judged in the ideal academic sense. This concept involves three assumptions: first, the physician possessed all the knowledge currently available relating to the factors involved in the death; second, by experience, he had reached a high level of technical ability; third, he had available to him all the facilities present in a well organized and properly equipped hospital. Because of the austerity of these criteria, it is then desirable to determine avoidable factors involved in the death rather than label the death preventable, and this is done in Table VII. As noted therein, professional factors were involved in all of the deaths classified as avoidable by the committee in 1977 and 1978.

The committee wishes to again acknowledge and commend the medical profession's support for this project in our state. Such support has been the cornerstone for the project's success.

2500 North State Street (39216)

for Knotts in the night

Prescribe new formula

Quinamm*

(quinine sulfate tablets)

each tablet contains quinine sulfate 260 mg



Specific therapy for painful night leg cramps

Merrell Dow

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Quinamm™
(quinine sulfate tablets)

CAUTION Federal law prohibits dispensing without prescription

BRIEF SUMMARY

INDICATIONS AND USAGE
For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS
Quinamm may cause fetal harm when administered to a pregnant woman. Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g.) for attempted abortion. In about half of these reports the malformation was deafness related to auditory nerve hypoplasia. Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes. In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys. Quinamm is contraindicated in women who are or may become pregnant. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency.

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use. Recovery usually occurs following withdrawal of the medication and appropriate therapy.

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever.

WARNINGS
Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism. Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision, however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin.

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine. Quinamm should be stopped immediately if evidence of hemolysis appears.

If symptoms occur, drug should be discontinued and supportive measures instituted. In case of overdosage, see OVERDOSAGE section of prescribing information.

PRECAUTIONS
General
Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS.). Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken. Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form. Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy.

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine. (See Drug Interactions.)

Drug Interactions
Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration. Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly.

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties.

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity.

Drug Laboratory Interactions
Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used.

Carcinogenesis, Mutagenesis, Impairment of Fertility
A study of quinine sulfate administered in drinking water (0.1%) to rats for periods up to 20 months showed no evidence of neoplastic changes.

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test. Intraperitoneal injections (0.5 mM/kg.) were given twice, 24 hours apart. Direct *Salmonella typhimurium* tests were negative, when mammalian liver homogenate was added, positive results were found.

No information relating to the effect of quinine upon fertility in animal or in man has been found.

Pregnancy
Category X. See CONTRAINDICATIONS.

Nonteratogenic Effects
Because quinine crosses the placenta in humans, the potential for fetal effects is present. Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown. Quinine in toxic amounts has been associated with abortion. Whether this action is always due to direct effect on the uterus is questionable.

Nursing Mothers
Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts).

ADVERSE REACTIONS
The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage (individual or multiple symptoms may represent cinchonism or hypersensitivity.)

Hematologic: acute hemolysis, thrombocytopenic purpura, agranulocytosis, hypoprothrombinemia.

CNS: visual disturbances, including blurred vision with scotomata, photophobia, diplopia, diminished visual fields and disturbed color vision, tinnitus, deafness and vertigo, headache, nausea, vomiting, fever, apprehension, restlessness, confusion, and syncope.

Dermatologic-allergic: cutaneous rashes (urticarial, the most frequent type of allergic reaction, papular, or scarlatinal), pruritus, flushing of the skin, sweating, occasional edema of the face.

Respiratory: asthmatic symptoms.

Cardiovascular: anginal symptoms.

Gastrointestinal: nausea and vomiting (may be CNS-related), epigastric pain.

DRUG ABUSE AND DEPENDENCE
Tolerance, abuse, or dependence with Quinamm has not been reported.

OVERDOSAGE
See prescribing information for a discussion on symptoms and treatment of overdose.

DOSAGE AND ADMINISTRATION
1 tablet upon retiring. If needed, 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring.

After several consecutive nights in which recumbency leg cramps do not occur, Quinamm may be discontinued in order to determine whether continued therapy is needed.

Product Information as of October 1980

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Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.

getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate* Dospan* ℞IV

(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense. And it's responsible medicine.

Merrell Dow

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York Raven Press, 1978, pp. 391-404.

Tenuate® ℞IV
(diethylpropion hydrochloride USP)

Tenuate Dospan® ℞IV
(diethylpropion hydrochloride USP) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

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The President Speaking

Watch Developments in Washington

R. FASER TRIPLETT
Jackson, Mississippi

Last November the voters in this country went to the polls and sent Ronald Reagan to Washington with a mandate to cut taxes and reduce the federal deficit. Most of the President's proposed budget cuts now have passed the U.S. Senate and House in some fashion, and a compromise between the two versions is all that remains in the way of drastic reductions in federal expenditures. Because the House and Senate had differing ideas on how to cut health expenditures, we still do not know exactly where all the cuts will come. Needless to say, the Republican dominated Senate proposals, with very few exceptions, follow more closely the Administration's budget recommendations.

The question that hits closer to home is how the cuts will affect Mississippi. In a report to the Mississippi Legislature prepared by the Governor's Office of Federal-State Programs, it is estimated that the President's budget recommendations, if enacted, would result in an approximate $171.2 million loss in federal funds. Obviously, not all of that would come from health-related items in the budget. However, under the broad category of "Health Programs," the report forecasts a $7.2 million reduction in federal funds from fiscal year '81 to fiscal year '82. And in Medicaid, the reduction is even more noticeable.

The proposed federal expenditures of $208 million for the Medicaid program in this state in fiscal year '82 is $37 million less than originally budgeted. It should be noted that the reduction of Medicaid funds is one of the differing points in Senate and House proposals. The House proposes to reduce federal matching funds by 3% in 1982, 2% in 1983, and 1% in 1984, while permitting states to recoup all or part of these cuts by enacting mandatory hospital rate-setting programs. The Senate, on the other hand, would lower the minimum federal matching from 50% to 40% and place a 9% cap on increases in federal matching funds for 1982. Both proposals would repeal the patient's freedom of choice; the House applying the repeal only to laboratory and drug services; the Senate applying the repeal to all services.

The Senate, following the President's proposal, would like to consolidate numerous health categorical grants into three block grants and reduce federal funding 25% below 1981 levels. The House would consolidate some of the categorical grants into block grants but continue others at 18-30% below 1981 funding levels. Both chambers call for an end of capitation grants to medical schools and a reduction of federal funding for health manpower training programs. (The House proposes a 25% reduction while the Senate calls for an end except for critical need manpower, i.e., nurses, family practice, pediatrics and general internal medicine.)

Both chambers agree on a phase-out for federal aid to HMOs with funds going only to those in the funding pipeline. The House would continue health planning at a reduced funding level while the Senate would reduce funding in '82 and end the program in '83. The House calls for an end to PSRO after an initial reduction in fiscal year '82, but the Senate wants to continue the program on a reduced level.

The cuts mentioned in these various programs will most certainly affect the delivery of medical care in this state. It is incumbent on the members of our profession to keep abreast of the developments in Washington and to seek to minimize the effect of these cuts on the delivery of patient care in Mississippi.

EDITORIALS

JOURNAL OF THE
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MEDICAL ASSOCIATION

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AUGUST 1981

Complications of Otitis Media

Otitis media, considered by many to be a simple, benign infection, can be associated with severe complications. Several recent cases, complicated by meningitis, brain abscess, and sigmoid sinus thrombosis, prompted a review of this problem. A brief summary of that review is presented here in hopes of alerting all practitioners to these possible complications.

Complications associated with otitis media may be intracranial, intratemporal, or extracranial.

Intracranial complications consist of meningitis, encephalitis, epidural abscess, subdural abscess, brain abscess, and thrombosis of the major venous sinuses, particularly those adjacent to the temporal bone. Any of these may exist as a single entity, or several may be present in any given patient. All are caused by spread of infection from the temporal bone to the adjacent intracranial structures by direct or hematogenous spread. Any patient presenting with otitis media and associated otorrhea with CNS signs should be thoroughly investigated and vigorously treated according to the findings.

Intratemporal problems associated with otitis media consist of mastoiditis, 7th nerve paralysis, labyrinthitis, and petrositis. Any patient with otitis media with associated vertigo, loss of hearing, or 7th nerve paralysis, should be immediately evaluated and treated.

Extracranial complications of otitis media consist of abscesses located on the inferior surface of the temporal bone (base of the skull) and these infections extend downward along the fascial planes of the neck. Occasionally, such an abscess will present in the posterior wall of the pharynx.

Any of the above may exist as a single entity or may be associated with multiple complications. Earlier, inadequate antibiotic therapy many times suppresses symptoms associated with these complications and makes diagnosis extremely difficult.

Any patient with otitis media, with or without drainage, and symptoms suggestive of any of the above complications, deserves immediate evaluation and treatment.

MYRON W. LOCKEY, M.D.
Associate Editor

Guest Editorial

A Plea for Utilization of Home Health Care

Home health care refers to a comprehensive array of health care services provided to a patient in the home. These services include periodic visits by a registered nurse, which may range from daily to monthly depending on the severity of the patient's problems. They also include physical therapy, occupational therapy, speech therapy, nurses aides and the furnishing of equipment and supplies.

It is a known fact that most patients are more comfortable in their own home. There he or she can enjoy their preference of food, visitors, and the relaxing atmosphere of family surroundings. There the family can become more involved with the patient's care.

Various studies have shown that the proper utilization of home health services can markedly shorten the hospital stay of patients suffering from myocardial infarction, congestive heart failure, orthopedic conditions, urinary tract infections and others too numerous to mention.

Why, I ask, are these services not more widely utilized? The answer frequently is the attitude of the attending physician who has been trained to treat the patient in an institutional setting. Through medical school, internship and residency we have been trained to treat the acutely ill. The ability to treat the chronically ill usually comes with practice and is not as satisfying.

The value of home health care services has

been a source of disagreement among physicians for the past several years. The majority of doctors approve of the services, but a sizeable percentage, probably 15% to 20% in my area, voice objections and in certain cases actually disapprove. As a long time advocate of home health I will attempt to allay some of the fears I have heard voiced.

One of the most common objections is that it is money wasted. Indeed, the fact is that expenditures for home health care represent money saved. In our regional hospital in Laurel, Mississippi, the cost per day per patient is $292.46. This hospital's census runs about 50% Medicare-Medicaid, and the reimbursement rate is $231.17 per patient day for Medicare-Medicaid. The private-pay patient makes up the $61.29 per day differential. In contrast, the average monthly cost of home health care is $222.44 per *month* for one patient. This covers an average of 10.1 visits per month. (These figures are obtained from the local home health agency I am most familiar with.) Further comparison reveals that the average monthly cost of care in a nursing home ranges from $1000 upwards.

Another objection voiced is that the doctor will lose control of the patient. Actually, the physician is completely in charge and manages the therapy, with the knowledgeable input of the R.N. who reports to him at regular intervals of the patient's condition, reaction to changes in medication, etc.

Of concern to some physicians is the fear that they will have to make more house calls when the patient is under home health care. In fact, the frequent visitation of the nurse and her periodic reports all but remove the demand for house calls.

As a physician who has practiced in a combined urban-rural setting for 35-plus years and who has watched so many of his patients become chronically ill and infirm, I am grateful for the help of the home health agencies. They enable me to give my older, homebound patients a degree of care that could not be achieved by rare clinic or home visits.

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RECOLLECTIONS

The June 1961 issue of JOURNAL MSMA reported news of the association's 93rd annual session. Dr. Lawrence Long of Jackson was inaugurated president, succeeding Dr. Swink Hicks of Natchez. Dr. C. P. Crenshaw of Collins was named president-elect. In other selections, Dr. C. G. Sutherland of Jackson was named secretary-treasurer, Dr. B. B. O'Mara of Biloxi was re-elected speaker of the House of Delegates, and Dr. Howard A. Nelson of Greenwood was renamed vice speaker.

The House of Delegates took action opposing the enactment of the King-Anderson bill providing for compulsory health care for the aged under the Social Security program, supporting instead the Kerr-Mills program to provide medical care for the aged citizens in need.

A filler item quoted Plato, *circa* 380 B.C. — "Democracy does not contain any force which will check the constant tendency to put more and more on the public payroll. The state is like a hive of bees in which the drones display, multiply, and starve the workers so the idlers will consume the food and the workers will perish."



During the AMA's recent annual meeting in Chicago, Dr. Lamar Weems of Jackson presided as chairman of Reference Committee C, which considered a number of reports and resolutions dealing with medical education.

Supreme Court to Hear Ethics

The question of whether the federal government has the right to forbid professional associations such as the AMA from enforcing ethical restrictions against advertising will be decided by the Supreme Court.

In a brief order, the Court agreed to hear the AMA's appeal from the 1979 FTC ruling that barred the AMA from involving itself in physician advertising unless the advertising would be "false or deceptive" as defined by the FTC. After an Appeals Court by a 2-1 vote upheld the FTC last October, the AMA went to the Supreme Court, declaring the case is of "enormous importance" because it allows the government to "prevent professionals who have voluntarily associated together from taking a position against promotional practices which they believe to be deceptive."

As is customary, the high court gave no explanation for accepting the case for review. A hearing will be held this fall, following the summer recess. A decision won't be issued until later, probably next year.

The AMA said that if the FTC is upheld "the real loser will be the public, often the poor or unsophisticated, who are drawn to incompetent practitioners by the meaningless testimonials, inflated promises, nonverifiable claims of superiority and outright lies that the AMA's 1976 statement (on advertising and solicitation) had condemned."

The Supreme Court was asked to hear the case "before responsible medical societies . . . simply abdicate the field to a government agency (FTC) which itself acknowledges that it is incapable of drafting precise guidelines."

PSROs Terminated

Forty-six Professional Standards Review Organizations (PSROs) have been marked for termination within 90 days.

The Health Care Financing Administration (HCFA) said the closing notices were sent "due to the severely reduced budget which Congress recently approved." Some $28 million was chopped from the $174 million allotment for the PSRO program. The PSROs threatened with an abrupt cutoff of federal funds may appeal the decision at hearings beginning in mid-July.

The Reagan Administration has proposed phasing out the PSRO program over the next few years as the administration's soon-to-be announced "pro competition" proposals for health care are phased in. The first PSROs to go were those rated poor performers in a recent evaluation of each of the 186 PSROs in the country by the Department of Health and Human Services. The Mississippi Foundation for Medical Care-PSRO was among those PSROs passing the evaluation.

Mississippi Heart Association Names New Officers



Jackson banker John P. Maloney, seated at right, assumed the office of president of the Mississippi Affiliate of the American Heart Association last month. Jackson cardiologist Dr. Quinton H. Dickerson, seated at left, was named president-elect. Other officers of the voluntary health agency are, from left, J. Herman Hines of Jackson, State Heart Fund chairman; Dr. Thomas J. Herrin of Jackson, secretary; Dr. Walter H. Rose of Indianola, immediate past president; Mrs. Ed Hill of Hollandale, vice president; William R. Boone of Jackson, treasurer; and William G. Shackelford, assistant treasurer.

Physician Art Association Seeks New Members

The American Physician Art Association (APAA) is seeking out physician artists who wish to join in the organization's endeavor of advancing physician art.

The APAA's annual meeting and art exhibit will be held Nov. 15-18 in New Orleans, in conjunction with the 75th annual meeting of the Southern Medical Association. According to Bruce Stoliar, M.D., editor-in-chief of *Metropolitan St. Louis Medicine* and a vice president of APAA, critics have described the exhibition as "one of the finest non-professional art shows in the country." Noted professional artists judge the show each year and award prizes.

Membership in the APAA is open to all physicians. For more information contact Milton S. Good, M.D., 610 Highlawn Ave., Elizabethtown, PA 17022.

NEW MEMBERS

BARKER, MARILYN ANN, Greenwood. Born Buffalo, NY, Jan. 5, 1950; M.D., State University of New York, School of Medicine, Buffalo, 1975; interned and pediatric residency, Buffalo Children's Hospital, Buffalo, 1975-77; elected by Delta Medical Society.

BYRD, OLIVER WAYNE, Quitman. Born Tupelo, MS, Jan. 1, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and family practice residency, University of Alabama, Huntsville, 1974-77; elected by East Mississippi Medical Society.

GELPERIN, ABRAHAM, Biloxi. Born Russia, Jan. 25, 1909; M.D., University of Cincinnati School of Medicine, Cincinnati, OH, 1932; interned St. Joseph's Hospital, Denver, CO, one year; dermatology residency, Cincinnati General Hospital, elected by Coast Counties Medical Society.

HODGES, REBECCA, Kilmichael. Born Winona, MS, Sept. 11, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and family practice residency, University Medical Center, Jackson, 1978-81; elected by North Central Medical Society.

MCCLOSKEY, JOHN J., Pascagoula. Born Pittsburgh, PA, May 21, 1943; M.D., St. Louis University School of Medicine, St. Louis, MO, 1969; interned and neurosurgery residency, University of Kentucky, Lexington, 1969-76; residency in neuropathology, University of Miami, FL, 1976-77; elected by Singing River Medical Society.

MCLEES, CHARLES THOMAS, Corinth. Born Greensboro, NC, Sept. 16, 1931; M.D., University of North Carolina School of Medicine, Chapel Hill, 1965; interned Medical College of Virginia, Richmond, one year; pathology residency, same, 1966-70; elected by Northeast Mississippi Medical Society.

RATLIFF, DONALD WAYNE, Belmont. Born Baldwyn, MS, May 17, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and family practice residency, University Medical Center, Jackson, 1975-78; elected by Northeast Mississippi Medical Society.

PERSONALS

JOHN R. BISE of Jackson attended the recent annual meeting Gynecologic Laser Society in Virginia Beach, Virginia.

KENNETH R. BENNETT has associated with the Jackson Heart Clinic, 971 Lakeland Drive, for the practice of cardiology.

EDGAR E. BOBO of Pearl, W. RICHARD CAMPBELL of Columbia and WILLIAM A. SPENCER of Sardis have completed requirements to retain active membership in the American Academy of Family Physicians.

MARK F. BROOKS announces the opening of his office for the practice of family medicine at 348 Crossgates Medical Plaza in Brandon.

W. J. CARR, JR., of Gulfport announces the relocation of his office for the practice of pediatrics to 100-F Oak Lane, Highway 49.

A. W. CONERLY of UMC was guest lecturer for the annual meeting of Respiratory Care Services in Bay St. Louis and spoke at the Bessemer Carraway Medical Center in Bessemer, Alabama.

W. MEL FLOWERS of UMC attended the annual meeting of the Society of Nuclear Medicine as a member of the organization's board of trustees in Las Vegas in June.

JOHN C. HALBROOK of Tupelo spoke at a Cancer Crusade meeting in West Point in June.

JAMES HARDY of UMC attended a meeting of the Board of Regents of the American College of Surgeons in Chicago in June and lectured in Paris, France and Cuenca, Equador, in May.

FREDERICK R. HECKLER of Jackson announces the association of G. ELI HOWELL, II, for the practice of plastic and reconstructive surgery at University Medical Center.

L. G. HOPKINS of Oxford recently was named Citizen of the Year by the Oxford Chamber of Commerce.

F. LEE HORN announces the opening of his office for the practice of family medicine at Medical Plaza in Houston.

JOHN J. MCCLOSKEY of Pascagoula announces his association with DONALD F. DOHN in the formation of Singing River Neurological Surgery, P.A. Dr. Dohn is former chairman of neurosurgery at Cleveland Clinic, Cleveland, Ohio.

J. N. MCQUEEN of Jackson announces the opening of an office at 439 North Jackson Street in Brookhaven for the practice of dermatology.

NORMAN NELSON of UMC was guest speaker at the Louisiana State University School of Medicine Alumni Conclave in June.

North Mississippi Hematology and Oncology Associates, Ltd., of Tupelo (CHARLES W. MONTGOMERY, JOHN C. HALBROOK, III, and SPENCER L. SCHREITER) announce the relocation of their offices to 806 Garfield St.

W. K. PURKS of Vicksburg was honored recently by the Mississippi Heart Association as one of the founders of the organization 30 years ago.

S. K. REDDY announces the opening of his office for the practice of internal medicine at Colonial Apt. No. 2 in Tylertown.

SUTHIN SONGCHAROEN of Jackson has been elected to fellowship in the American College of Physicians.

JAMES T. THOMPSON of Moss Point was appointed to the board of trustees of Singing River Hospital System by the Jackson County Board of Supervisors.

JOHN J. TOOHIG announces the opening of his office for the general practice of medicine at 9170 Pigeon Roost in Olive Branch.

DEATHS

BROWN, WINFRED E., Grenada. Born Camden, NC, May 28, 1911; M.D., Tulane University School of Medicine, New Orleans, 1939; interned Baptist Hospital, Memphis, TN, one year; died June 23, 1981; age 70.

WEATHERFORD, WILLIAM J., Pascagoula. Born Uriah, AL, Dec. 29, 1905; M.D., Duke University School of Medicine, Durham, NC, 1933; interned Watts Hospital, Durham, NC, one year; surgery residency, City Hospital, Mobile, AL, one year; died May 18, 1981, age 75.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

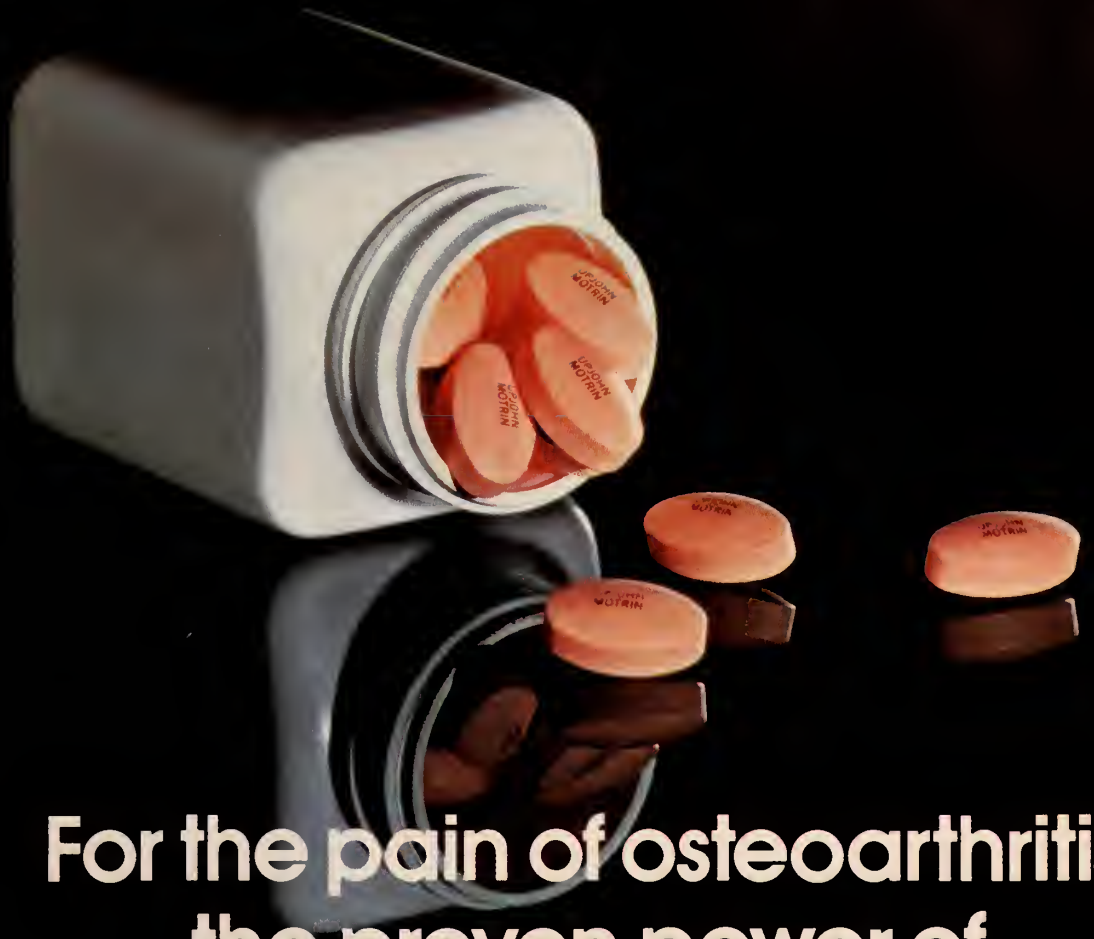
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In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*



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Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin*; use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.
Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness;* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

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Medico-Legal Brief

Patient Ordered to Undergo Necessary Care

A pregnant patient was properly ordered to undergo a sonogram, a cesarean section and other procedures to protect the life of her 39-week-old fetus, the Georgia Supreme Court ruled.

The patient had been seen by a physician at a county hospital for prenatal care. He found that she had a complete placenta previa and that the afterbirth was between the child and the birth canal. He found that it was virtually impossible for the condition to correct itself and that there was a 99 per cent certainty that the child could not survive natural childbirth. The chances of the mother surviving a vaginal delivery were no better than 50 per cent. Deliver by cesarean section prior to labor would have almost a 100 per cent chance of preserving the life of both the child and the mother.

On the basis of religious beliefs, the patient refused to submit to a cesarean section or a blood transfusion. The county hospital authority petitioned a trial court for an order authorizing a cesarean section and other necessary procedures. The trial court granted temporary custody of the unborn child to the county and authorized it to make all decisions, including consent to a cesarean section. The temporary custody was to determine when the child was successfully born or when it died.

On appeal, the Supreme Court denied the parents' motion to stay the order. The court weighed the right of the mother to practice her religion and to refuse surgery on herself against her unborn child's right to live and found in favor of the child's right to live. The child was facing almost certain death and was being deprived the opportunity to live, the court said. — *Jefferson v. Griffin Spalding County Hospital Authority,* 274 S.E.2d 457 (Ga.Sup.Ct., Feb. 3, 1981)

POSTGRADUATE CALENDAR

Oct. 6, 1981
Mississippi Thoracic Society Meeting and Boswell Lecture
Jackson, Mississippi

Oct. 14-17, 1981
Family Practice Update
Jackson, Mississippi

Dec. 10-11, 1981
Perinatal Postgraduate Course
Jackson, Mississippi

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PLACEMENT SERVICE

Physicians Wanted

ANESTHESIOLOGIST to join large community hospital. Contact Tom Askew, Administrator, Greenwood-Leflore County Hospital, Greenwood, MS 38930.

GENERAL PRACTICE opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

SURGEON to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

GENERAL PRACTICE opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

BOARD ELIGIBLE INTERNIST seeks practice location; M.D. from University of Texas at Southwestern. Contact Stephen R. Cherry, M.D., 7061 B Creekview Trail, St. Louis, MO 63123.

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OBSTETRICIAN-GYNECOLOGIST to join 15-member multispecialty group, associated with JCAH-approved hospital. Associate partner status first year with guarantee plus percentage. No investment. Contact Karl Hatten, M.D., or H. Dean Andrews, Administrator, Vicksburg Clinic, Vicksburg, MS 39180.

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IN CONCLUSION

Eye damage due to sports injury has risen significantly since 1973, and the most dangerous sport for the ages 5-14 is baseball, says a report in the July 10 issue of JAMA. More than 12% (35,000) of all eye injuries reported in 1978 were caused by sports, a 58% increase over 1973 figures. Nearly one-third of these injuries afflicted the elementary-school age group. Baseball accounted for 26% of the injuries. Basketball was the leading cause of eye injuries in the 15-24 age group, and racquet sports caused more in the over 25 age group.

Breast feeding mothers can use oral contraceptives safely even though the quantity and ingredients of their breast milk may change as a result, according to the American Academy of Pediatrics. Guidelines on birth control for lactating mothers were published in the July issue of Pediatrics. Issued as a policy statement, the guidelines were written in order to clarify "confusing recommendations" which have been made regarding the effects of various contraceptive methods on breast milk and nursing infants, the Academy said.

The Feingold diet eliminating artificial food colorings on the presumption that the additives are responsible for hyperactivity in small children has been tested and found wanting as a cure for hyperactivity, according to an article in the June issue of Archives of General Psychiatry. The study was conducted among children age 4 to 13 who had reportedly responded to the diet. Evaluation by parents, teachers and psychiatrists and psychological testing yielded no evidence of a food coloring effect on hyperactivity.

Despite advances in the medical management of kidney transplants, fewer patients now on dialysis can look forward to receiving a donor kidney. The reason is that an increasing number of prospective kidney recipients have become sensitized to the foreign proteins that are likely to be encountered in a donor kidney, according to a group of investigators writing in the July 10 issue of JAMA. Pre-transplant blood transfusions and prior rejected transplants were cited as possible factors.

The American Society of Internal Medicine (ASIM) has formally endorsed About Your Medicine, a lay-language drug-use reference book published by the United States Pharmacopeial Convention (USP). The ASIM stated that it considered the book an innovative private sector initiative and voluntary alternative to mandatory patient inserts, and urged physicians to use the book to provide drug information to their patients. USP grants permission to prescribers and dispensers to photocopy appropriate pages to provide to patients.

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in shigellosis...
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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note.* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General.* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias.* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions.* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults. Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment. Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

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PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med 303* 426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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September 1981

JOURNAL of the MISSISSIPPI State Medical Association

This Month:

Impotence — Whose Fault Was It?

On the Field Knee Exam for the Team Physician

Obstetrics and Gynecology Grand Rounds: Clinical Case Management

Hepatobiliary Imaging

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) Ⓝ, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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September 1981, Volume XXII, Number 9

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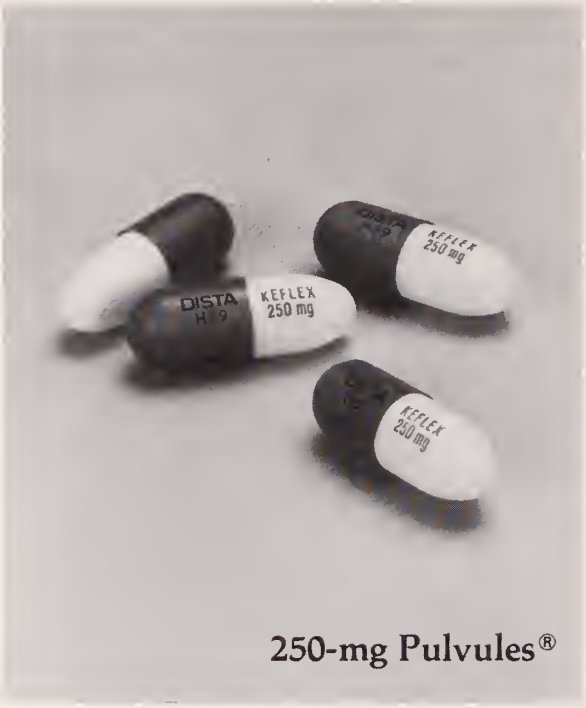
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"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

__CONTRAINDICATIONS__: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

__WARNINGS__: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination
USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilicel-cord blood at or near maternal plasma levels and in breast milk of lectating mothers et concantrations two to four times that of maternal plasma. When use of meprobamate is contamplated in breast-feeding patients, the drug's higher concentration in breast milk as compered to maternal plasma levels should be considered.
Preparations containing aspinn should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

__PRECAUTIONS__: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma shock vasomotor and respiratory collapse, and anuna Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g caffeine Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

__ADVERSE REACTIONS__: A small percentage of patients may expenence nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticanal or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses peripheral edema and lever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine and possibly hydrocortisone Meprobamate should be stopoed and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case) thrombocytopenic purpura agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported most of these returned to normal without discontinuation of the drug
Impairment of accommodation and visual acuity has been reported rarely

__OVERDOSE__: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspinn have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropnate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspinn would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs usually requires whole-blood translusions

__DESCRIPTION__: Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspinn

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101



for mild to moderate pain

Wygesic®(IV)

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g., driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume; Cheyne-Stokes respiration; cyanosis); extreme somnolence progressing to stupor or coma; pupillary constriction and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine, and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g., caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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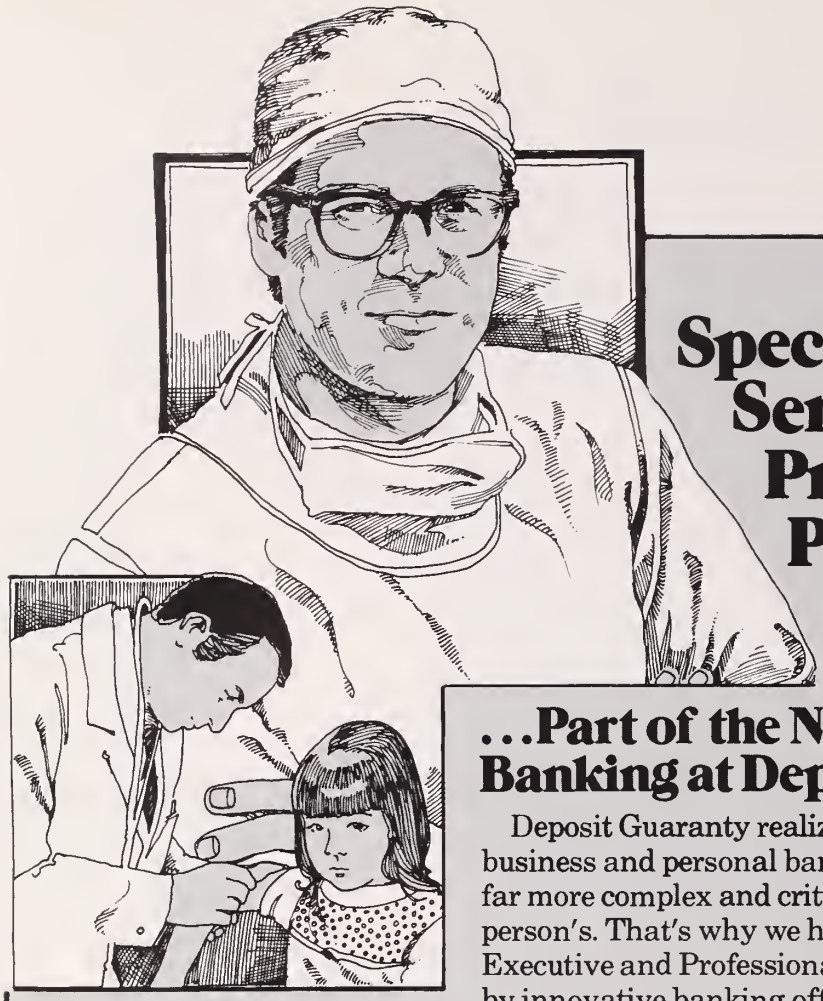
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NEWSLETTER

September 1981

Dear Doctor:

One Mississippi community's success in recruiting two physicians and providing a medical clinic was the subject of a feature article in a recent Sunday issue of the Clarion Ledger/Jackson Daily News. Of particular interest and emphasis in the article was the role played by Dr. Arthur Derrick of Durant in the successful recruiting effort for his community. Dr. Derrick is a former MSMA president and board chairman.

> The article also noted that the people of Durant sought no federal money and constructed a $50,000 medical clinic financed entirely with local contributions. Community-wide fund raising activities and donations of money, equipment, supplies, labor, etc. enabled the town to build the clinic.

Literature on physician recruitment is available from the MSMA headquarters office. Also available is literature on another current topic - organizing a health education program. Beginning this fall, Mississippi public schools are required to have health education programs. Input from the local medical community can have an impact on the health education programs in local schools.

The Center for Disease Control in Atlanta is warning the public about widely-promoted, ineffective treatments for genital herpes. The CDC also urges physicians to warn patients about the ineffective treatments, which include vaccines for smallpox, polio, tuberculosis, yellow fever and influenza, and other substances such as interferon, steroid creams and vitamins C, E and B-12.

Physicians' fees rose 0.7% in June, according to the Consumer Price Index. The rate of increase was slower than that for all items (0.9%) and all services (1.3%). The overall medical care index went up 0.9% in June, led by hospital room charges (1.1%), charges for prescription drugs (1.1%), and charges for dental services (1.0%).

Syndicated columnist and lecturer Abigail Van Buren will be the guest speaker for the MSMA and MSMA Auxiliary banquet during the 114th Annual Session, May 2-6, 1982, in Biloxi. Other special activities are being planned for the annual session, which will celebrate MSMA's 125th anniversary. Make plans now to attend, and please watch future issues of Journal MSMA for more details.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*



For the pain of osteoarthritis the proven power of

Motrin®
ibuprofen, Upjohn
600 mg Tablets
One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

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Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels. *Coumarin:* bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

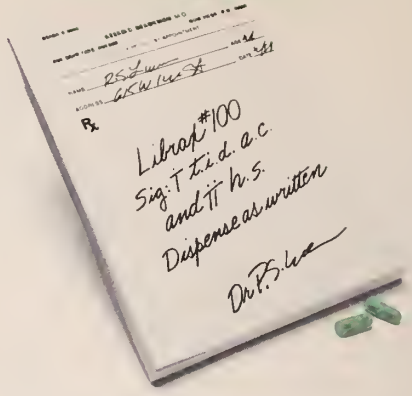
Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-5-S

J-9042-4

July 1981

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Adjunctive

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/ Antispasmodic

*Librax has been evaluated as possibly effective for these indications. Please see summary of prescribing information on facing page.

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. Dyazide® interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with Dyazide®, but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and Dyazide® should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Dyazide® should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of Dyazide®, although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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DATELINE

Pulmonary Disease Seminar Planned

Hattiesburg, MS - A seminar on pulmonary disease will be held at Forrest General Hospital on Nov. 12. Lecture topics include: advances in asthma, non-ventilator management of COPD, pulmonary function tests, advances in granulomatous disease, and evaluation of pneumonia. Forrest General Hospital and the Hattiesburg Clinic, PA, are co-sponsors. For more information, write to the CME Dept., Hattiesburg Clinic, 415 S. 28th Ave., Hattiesburg, MS 39401.

RMSF Incidence In Mississippi

Jackson, MS - The 1981 incidence of Rocky Mountain spotted fever in Mississippi is virtually the same as 1980, reports the State Board of Health. So far 19 cases have been reported, and distribution, age, sex, race and fatality rate (about 10%) are following a pattern similar to 1980. Nationwide, there has been a 25% increase in the disease. The CDC in Atlanta says the fatality rate has averaged 5% for ten years.

Drug Approval Process Under Study

Washington, DC - A commission of members of the academic, governmental and private sectors has been created to study and recommend ways to reform the FDA's drug approval process. Their report, due before Congress by Feb. 1, 1982, will recommend ways to shorten the FDA's procedures for approval of new drugs and develop cost-effective surveillance processes that guarantee quick withdrawal from the marketplace of drugs causing significant adverse affects.

Medical Practice Profile Published

Chicago, IL - The nation's physicians spent more time with their patients in 1980. Physicians had an average of 112 patient visits per week, compared to 122.7 visits in 1979 and 130.6 in 1978, but the physicians' work week continued about the same - 44.5 hours of direct patient care in 1980, compared to 44.9 hours in 1979 and 45.2 hours in 1978. These figures are from the new 10th edition of Profile of Medical Practice, published by the AMA.

AMA Favors Medical Information System

Chicago, IL - Computerized medical information systems, with proper peer review, would aid the advancement of medical practice, the AMA said in a statement to two subcommittees of the House Committee on Science and Technology. The AMA recommended that the development of such systems be left to the private sector, where competition would result in designs appropriate to varied medical needs. The statement opposed a federal system which would violate patients' privacy.

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Quinamm*

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each tablet contains quinine sulfate 260 mg



Specific therapy for painful night leg cramps

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Quinamm™
(quinine sulfate tablets)

CAUTION Federal law prohibits dispensing without prescription

BRIEF SUMMARY

INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion In about half of these reports the malformation was deafness related to auditory nerve hypoplasia Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys Quinamm is contraindicated in women who are or may become pregnant If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use Recovery usually occurs following withdrawal of the medication and appropriate therapy

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision, however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine Quinamm should be stopped immediately if evidence of hemolysis appears

If symptoms occur, drug should be discontinued and supportive measures instituted In case of overdosage, see OVERDOSAGE section of prescribing information

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice, 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver homogenate was added positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy

Category X See CONTRAINDICATIONS

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage (Individual or multiple symptoms may represent cinchonism or hypersensitivity)

Hematologic acute hemolysis, thrombocytopenic purpura agranulocytosis hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata photophobia diplopia, diminished visual fields and disturbed color vision tinnitus deafness and vertigo headache nausea vomiting fever apprehension restlessness confusion, and syncope

Dermatologic allergic cutaneous rashes (urticarial the most frequent type of allergic reaction papular or scarlatinal) pruritus flushing of the skin sweating occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related) epigastric pain

DRUG ABUSE AND DEPENDENCE

Tolerance abuse, or dependence with Quinamm has not been reported

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment of overdose

DOSAGE AND ADMINISTRATION

1 tablet upon retiring If needed 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not occur Quinamm may be discontinued in order to determine whether continued therapy is needed

Product Information as of October 1980

Licensor of Merrell*

MERRELL-NATIONAL LABORATORIES Inc
Cayey Puerto Rico 00633

Direct Medical Inquiries to

Merrell

DOW

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(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.

(polymyxin B-bacitracin-neomycin)

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Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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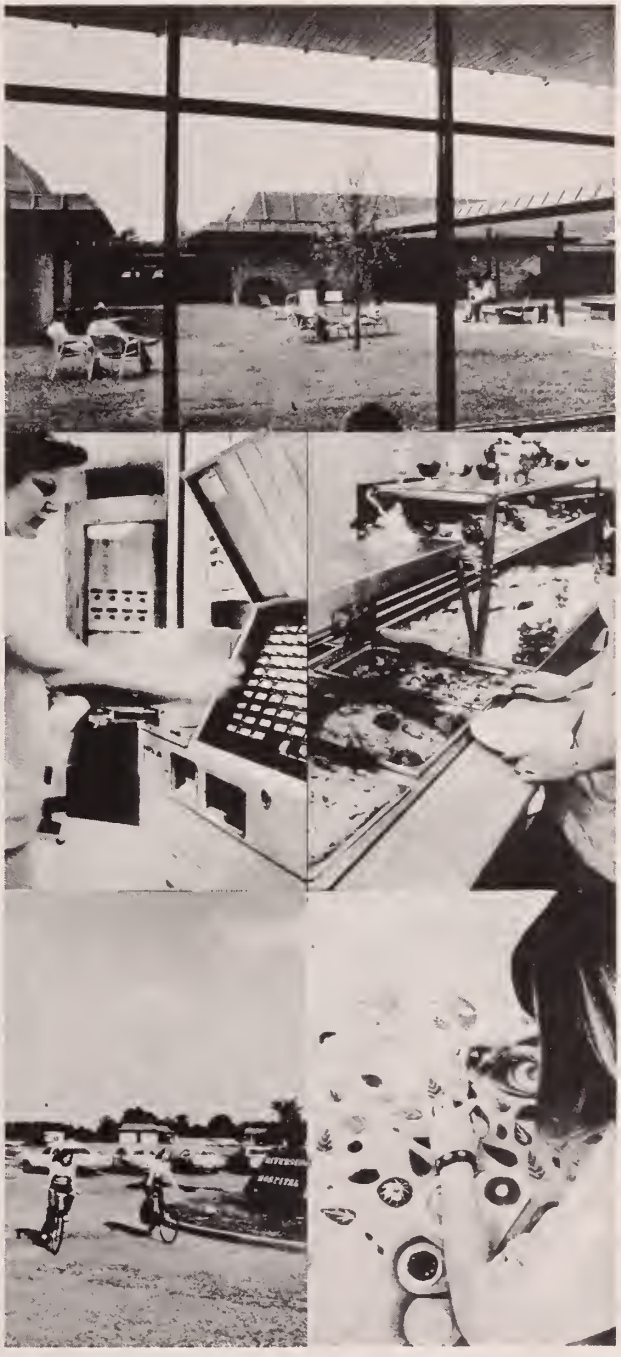
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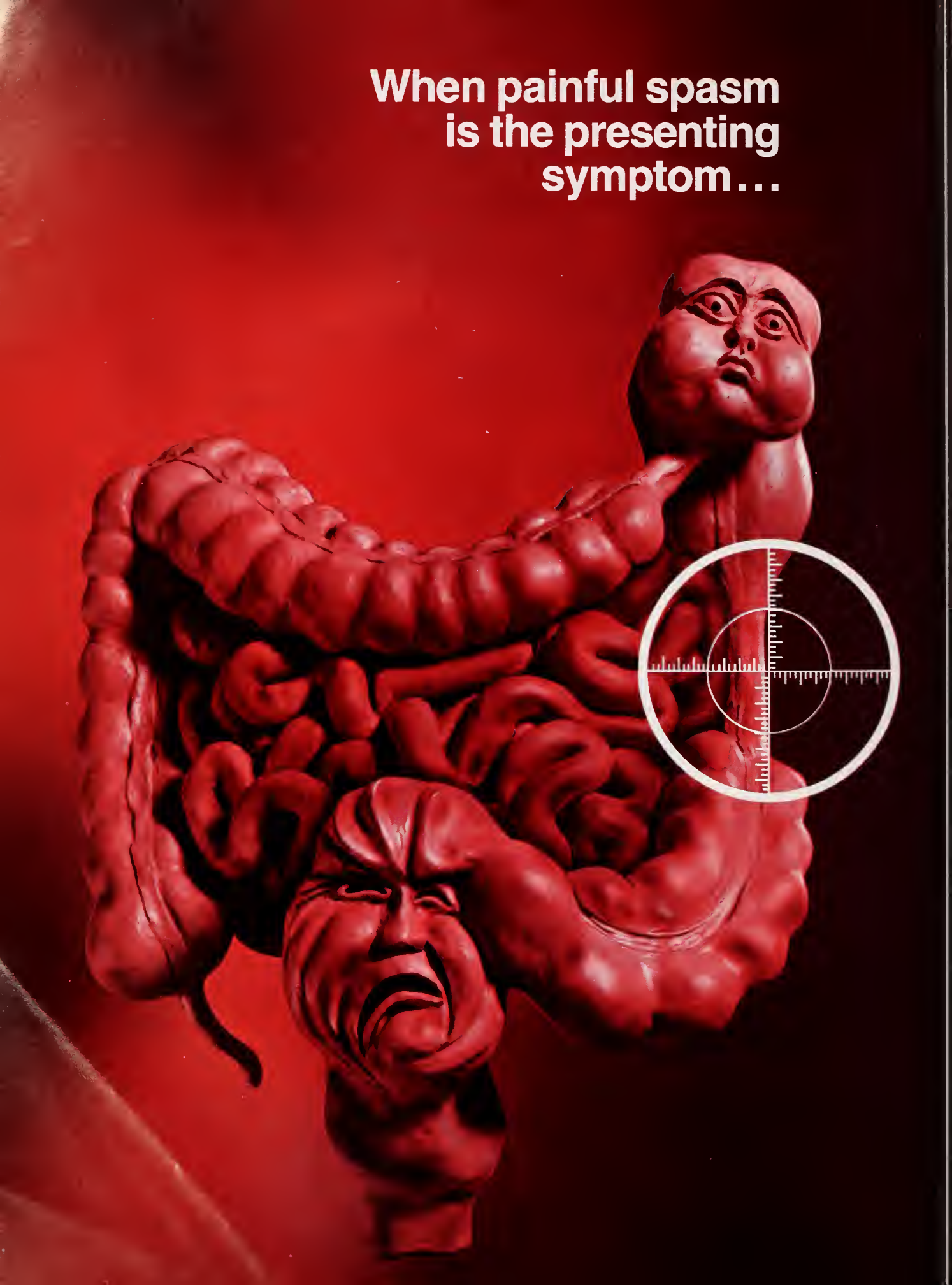
Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



Riverside Hospital

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When painful spasm is the presenting symptom...



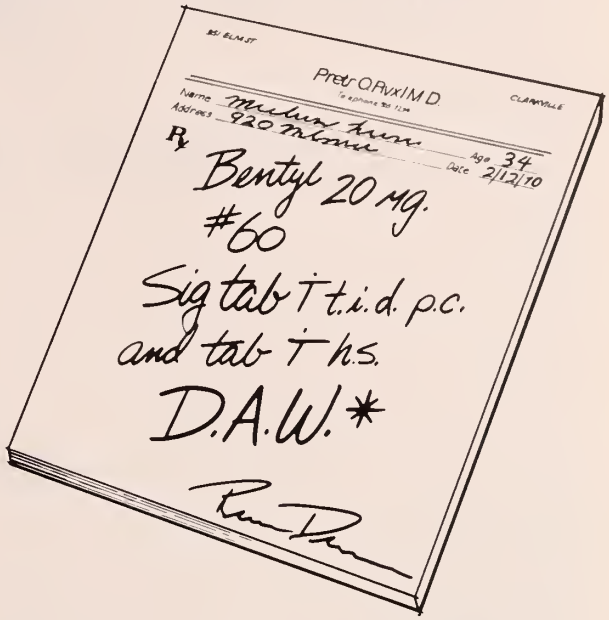
...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl®

(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



*D.A.W.-Dispense as written

because:

- The Bentyl molecule is a product of original Merrell research.
- At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- Significant pharmacologic effect in the distal colon compared to placebo,[1] shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:
1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness, drowsiness; weakness, dizziness, insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults*, 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*, 1 capsule or teaspoonful syrup three or four times daily. *Infants*, ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults*, 1 tablet three or four times daily.

Bentyl Injection: *Adults*, 2 ml. (20 mg.) every four to six hours intramuscularly only.
NOT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine* (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
SEPTEMBER 1981, VOL. XXII, NO. 9

ORIGINAL PAPERS

Impotence — Whose Problem Was It?

TOXEY M. MORRIS, M.D.
Hattiesburg, Mississippi

SEXUAL IMPOTENCE IN MALES is defined in this discussion as failure to achieve an erection, or failure to maintain penile erection long enough to effect intromission. This definition will be used in this article, recognizing that other forms of impotence such as ejaculatory failure or premature ejaculation play a major role in sexual dysfunction.

Historically many of us were taught that 90%-95% of male impotence was psychogenic, and we often assigned the problem to the patient to solve. Perhaps in doing that we were unconsciously grateful that it was "his" problem and not "ours."

However, recent progress in diagnostic capability and in the technology of prosthetics has forced us to re-examine these problems and share increasing responsibility for their solutions.

Very recent studies indicate that male impotence may be of truly psychogenic origin in as little as 38% of cases.[1] That statistical presentation may not make those men with psychogenic impotence feel any better about the situation, but it can make us as physicians more comfortable in recommending thorough diagnostic evaluation in *all* cases of impotence.

Common organic etiologies have been recognized in diabetes mellitus (25%-55% of diabetic males from ages 30-60 years suffer some form of impotence),[2] drug-induced impotence due to certain antihypertensives, hypogonadism due to any one of a number of causes, post-surgical impotence or vascular insufficiency, and many other disease states.

Dr. Morris is a practicing urologist in Hattiesburg, MS.

Penile vascular insufficiency deserves special mention. Erection is a phenomenon brought on by engorgement of the corpora cavernosa from arterial flow of blood via the deep penile arteries, supplied by the pudendal arteries and the internal iliacs. If the blood supply is limited, then erection will be limited. We do not hear of penile angina or penile claudication, but rather of erectile failure. One must not forget that the same widespread atherosclerotic process that brings on myocardial ischemia, transient cerebral ischemia, or intermittent claudication can exist in the iliac and pudendal arteries as well as in any other vessel.

Recent diagnostic application of existing modalities, including penile pulse volume recordings (PVR), Doppler studies of the deep penile arteries, nocturnal penile tumescence monitoring (NPT), and most recently, intraurethral temperature differentials, has provided interesting information and objective guidelines for diagnosis.

Abelson and others have shown that diminution of the penile PVR, or a difference of 30 MM Hg between the penile systolic pressure and the brachial systolic pressure as measured with the Doppler stethoscope is clinically significant.[3] A differential of 3 degrees between intraurethral and sublingual temperatures is thought to be significant.[4]

Once the clinician has taken the burden of responsibility from the patient and established a diagnosis, he must be prepared to offer a solution. One such solution, a surgical one, is presented here.

Since the early 1950s surgeons have attempted to treat impotence with modern synthetic materials,

based on the fact that some animals possess an os penis.

In 1964 and 1968, Pearman and Lash in separate presentations described insertion of silicone prostheses in impotent patients with satisfying results.[5]

More recently, Scott and associates have developed an implantable, inflatable prosthesis.[6] The early reports are generally favorable, but the reoperation rate for mechanical failure has seemed high. Small and Carrion have developed a penile implant composed of a silicone sponge interior and silicone exterior which is implanted directly into the corpora cavernosa to produce a semi-rigid "permanent" erection.[7] The success rate of this procedure at our institution and others has been high, and the reoperation rate is very low. The expense is relatively low and hospital stay is quite short, approximately three days. Sexual excitement can add to the post-implant erection, and if the ejaculatory mechanism is undisturbed, orgasm and ejaculation occur as before. Concealment has not been a problem in any of our patients, who report that at most, wearing well-fitting jockey shorts prevents any embarrassment. The characteristic immediate postoperative appearance of the Small-Carrion prosthesis is shown in Figure 1, and a one year follow-up is seen in Figure 2. The prostheses, paired, tapered cylinders available in sizes from 6 cm to 23 cm long, are shown in Figure 3. Access to the corpora cavernosa for insertion of a properly measured prosthesis is gained via a midline perineal or dorsal penile incision, as shown in Figure 4.



Figure 1. Immediate post-implant appearance of the penis in case 2. The Foley catheter remains only overnight.

Case 1

A 46-year-old divorced white male executive was referred by his cardiologist with complaints of erectile failure for four years. In that time, he had suffered myocardial infarction necessitating a two-artery coronary bypass. Further peripheral atherosclerotic disease had necessitated aortic replacement and aorto-iliac bypass grafting. The patient's wife had divorced him two years prior to this referral. Subsequently he had formed a relationship with another female, but was totally unsuccessful in achieving erection. There was no evidence of diabetes, and endocrine evaluation was normal. Libido was normal. He successfully underwent insertion of a Small-Carrion prosthesis and currently has a satisfactory sexual relationship. On his last office visit, his only expressed regret regarding the surgery was that he had not had it performed before his wife decided to divorce him.

Unfortunately, penile PVR and Doppler studies were not available to us at the time of his surgery, but in all likelihood they would have confirmed our clinical impression of penile vascular insufficiency. An alert and informed cardiologist has improved this man's lifestyle in many ways.

Case 2

A 56-year-old black male had undergone radical retropubic prostatectomy for adenocarcinoma of the prostate. While he did not deny that he had been fully informed of the near certainty of postoperative



Figure 2. One year postoperative follow-up in a 75-year-old man impotent after resection of an abdominal aneurysm. He and his wife are pleased with the result.



Figure 3. The paired silicone prostheses should be inserted in the corpora cavernosa so that the tapered end fits firmly against the ischial tuberosity and the rounded end snugly under the glans penis. Sizes range upward from 6 cm to 23 cm on special order.



Figure 4. Access to the paired corpora via a penile incision. Note the flexibility of the prosthesis as it is inserted.

impotence, the full impact of this struck him about one year after his surgery. He is married to a 42-year-old female. He presented with severe depression, vague and fleeting aches and pains, and multiple somatic complaints. Thorough evaluation revealed no evidence of metastasis. He was known to be mildly diabetic. He and his wife accepted the idea of penile prosthesis readily, and after insertion of a Small-Carrion prosthesis were able to complete the sexual act ad libitum. We did not reasonably expect this man to experience orgasm, the prostate and seminal vesicals being surgically absent, but he has stated "the feeling is the same." Of course, there is no ejaculation.

While neither patient required complicated diagnostic maneuvers to define the cause of his impotence, these cases appeared early in the series, and now less clear-cut cases might require such measures as penile PVR's, Doppler studies, and possibly nocturnal penile tumescence monitoring to assure the surgeon and the patient of the organic nature of the "problem."

It has been interesting to observe the relief expressed by some of these patients when the organic cause of their impotence was explained — in other words, "it's not all in your head." However, if the diagnosis of psychogenic impotence is made, the patient is not necessarily excluded from surgical consideration. Some patients with psychogenic impotence are indeed candidates for surgical therapy, but patient selection must be meticulous. Sexual partners generally report satisfaction with the procedure. The availability of prosthetic devices with a 95% success rate assures the patient that gradual or sudden cessation of sexual activity will not occur without any control on his part. This is particularly reassuring to patients facing radical pelvic or extirpative surgery.

In summary, a solution-oriented approach to the problem of impotence is presented, and a surgical solution with high probability of success is described. This brief presentation does not deal with the intricacies of surgical technique, or the possible complications of implantation of a foreign body in this area. We hope it will serve to acquaint practitioners with the availability of surgical relief from impotence and allow those who see this problem primarily to take a solution-directed stance. ★★★

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References

1. Wesson, L. F., Sessions, R. P. and Fried, F. A.: Montague-Boyd prize-winning essay Southeastern Section AUA Meeting, March 25, 1981 (to be published).
2. Smith, A. D.: Causes and classification of impotence. Urol. Clin. N. Am. 8:87, 1981.
3. Abelson, D.: Diagnostic value of the penile pulse and blood pressure. J. Urol. 113:636, 1971.
4. Jevtich, M. J.: Penile body temperature as screening test for penile arterial obstruction in impotence. Urology 17:2, 1981.
5. Lash, P. H., Zimmerman, D. C. and Loeffler, R. A.: Silicone implantation: Inlay method. Plast. and Recon. Surg. 34:75, 1964.
6. Scott, F. B., Bradley, W. F. and Timm, G. W.: Management of erectile impotence: Use of implantable, inflatable prosthesis. Urology 2:80, 1973.
7. Small, M. P., Carrion, H. M. and Gordon, J. A.: Small-Carrion penile prosthesis: New implant for management of impotence. Urology 5:479, 1975.

On the Field Knee Exam for the Team Physician

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With the increasing interest in athletics and athletic participation, there is also an increasing need for the team physician concept. Although the position of team physician carries with it a great deal of excitement and reward, it also carries a great deal of responsibility. A team physician should be available to the team trainer and athletes on a 24-hour basis during the football season. On the field participation by the doctor is also highly necessary and desirable both in the preseason and on the night of the games. The team physician should also have a working knowledge of and be up to date on the latest aspects of sports medicine.

Since an injury to the knee is the most frequent and most debilitating of those which occur during American football, the team physician should have some knowledge as to the diagnosis of acutely injured knees. The team physician, although he may be a general practitioner or family practitioner, can have an excellent knowledge of the extent of injury to a knee by being familiar with several simple tests.

Mechanism of Injury

The most critical part of the knee evaluation is observation of the mechanism of injury. While the team physician is on the sideline, he should be watching the play of the athletes very carefully. When an athlete is hurt, the physician should take note of whether it was a contact or non-contact injury. He should also note whether the athlete was able to walk immediately after the injury, or whether he was carried from the field. It is also important to note whether the athlete had a "sensation of giving way" or a "pop" at the time of injury. Immediate swelling within two hours or late swelling the next day is also important to note. The absence of swelling is also a critical point. The fact that there is no swelling in the knee can often be misleading. The majority of severe ligamentous injuries will have either no swelling or very minimal swelling in the knee. The fact that there has been immediate swelling within 10-15 minutes or the knee is swollen by the time the player reaches the sidelines is indicative of several conditions. The first and foremost of these is an anterior cruciate ligament tear. When this ligament is torn there is usually an immediate hemarthrosis in the knee joint. Usually there are other ligamentous injuries or meniscal injuries associated with this. Several other conditions must also be considered when there is an immediate hemarthrosis. Of these, the second most common is the dislocation of the patella. This is a frequently missed injury in the athlete because it is oftentimes not considered in the differential diagnosis. Also, a peripheral tear of a meniscus should also be considered. Once the player is on the sideline, very careful history of the mechanism of injury can be taken from the player by the physician.

Observation and Palpation

Once the athlete is removed from the field, he should be placed on the sideline bench and relaxed as much as possible. The physician should first take a very close look at the knee. He should note any scratches or abrasions or areas of ecchymosis. Any areas of localized swelling, hematoma, or the presence of a mild or moderate hemarthrosis of the injured knee should be noted. These localizing signs can often point to the area injured or from which direction the knee was injured in a contact injury. Next, the knee should be very carefully palpated, including the femoral and tibial insertions of the medial and lateral ligament complexes. Also, the joint lines on the medial and lateral side of the knee should also be palpated very carefully. Tenderness in these areas is often indicative of the location of the ligament rupture or injury. Joint line tenderness is often indicative of a peripheral meniscal injury. The medial aspect of the patella should also be palpated to check for tenderness. An attempt to sublux or

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dislocate the patella laterally should also be tried. Tenderness on the medial aspect of the patella is often indicative of a patella dislocation.

Ligamentous Examination

The team physician is in a unique position on the sideline. He has an opportunity to examine the athlete's knee prior to the onset of muscle spasm. Muscle spasm will usually occur within several hours. When examined immediately, before spasm occurs, the ligamentous exam will not be painful and the athlete will not be able to guard against accurate testing. By the time the athlete has reached the emergency room, muscle spasm has occurred and any ligament looseness in the knee will often be masked. One must remember then that if a ligament instability or positive test is noted on the sideline by the team physician, this is considered positive until proven otherwise by an examination under anesthesia. There are several simple tests, illustrated below, that can be learned and performed with ease by the team physician.

The player should be in a reclining position with his hands crossed on his abdomen in order to relax. His head should also be down. In this position, the hamstring muscles are completely relaxed and will not interfere with testing. The first step of the knee exam is to examine the uninjured knee. This will give the team physician some idea as to the normal ligamentous laxity of the player. He should next move on to the injured knee. There are several simple tests which should then be performed in a logical order.

Lachman test (see Figure 1): The simplest and most logical test to do first is the Lachman test. This test is essentially painless and will probably give you a great deal of information. This test is perhaps the most specific for an anterior cruciate ligament tear of any of the tests. Place one hand on the anterior aspect of the distal femur just proximal to the knee joint and the other hand cupped behind the proximal tibia. With the knee flexed approximately 5 degrees, the tibia is drawn forward. If there is an abnormal sensation of the tibia moving forward as compared to the normal knee, this is considered a positive test. If the test is considered questionable, then it is positive. Normal knees should be examined prior to the season in order to get the sensation of a definite "end point" of an intact anterior cruciate ligament. A positive Lachman test will be lacking this definite strong end point. Pre-season physical examinations of the athletes provide excellent opportunities to become accomplished in these tests.

Abduction stress test (see Figure 2): Abduction stress test is logically performed next. The injured knee is flexed approximately 30 degrees and draped on the side of the bench. One hand is placed on the lateral aspect of the distal femur or the joint line and the other hand should grasp the medial aspect of the foot. A gentle valgus stress is then applied to the knee and a sensation of "opening" is elicited on the medial side of the knee. Once this has been elicited and is greater than the normal knee, the test is considered positive and deserves further examination.

Adduction stress test (see Figure 3): The adduction stress test logically follows. The hand positions are simply switched. One hand is placed on the inner aspect of the distal femur or the medial aspect of the joint and the other is placed on the lateral aspect of the foot. A gentle varus stress is applied to the knee. Any opening of the lateral aspect of the joint that is increased from the normal knee is considered positive.



Figure 1. Lachman test.



Figure 2. Abduction stress test.

Anterior drawer test (see Figure 4): The knee is then gently flexed to approximately 80 degrees. The examiner then sits on the player's foot in order to stabilize it. The hands are then cupped around the proximal tibia with the thumbs on the anterior tibial eminence on the medial and lateral plateaus. The tibia is gently pulled forward and any translation of the tibia on the femur is considered positive. This is often positive in a ligamentous injury to either the medial or lateral side in conjunction with the anterior cruciate ligament injury.



Figure 3. Adduction stress test.



Figure 4. Anterior drawer test.



Figure 5. "Jerk" or pivot shift test.

"Jerk" or pivot shift test (see Figure 5): Perhaps the most difficult test to master is the jerk test. This test is specific for anterior cruciate and lateral compartment injuries. The knee is flexed to approximately 30 degrees. If one is examining the left knee, the left hand is placed on the foot internally rotating the tibia. The right hand is placed on the distal femur and a valgus stress is applied with this hand. The leg is then brought into extension and a definite "jerk" or "shifting" sensation can be felt. Oftentimes the athlete will state that this is the sensation which he had on the field. This test requires some practice to master and should be done on every normal knee in the pre-season physicals.

Cross-over test (see Figures 6a, b): The cross-over test is a simple modification of the jerk or pivot shift test that can be performed easily by the athlete and the physician. In a standing position, the examiner places his foot on the foot of the injured player. The player is then asked to cross the normal leg over the injured leg and place the foot at a right angle to the injured foot. He is then asked to do a squat. As you can see from the illustration, this imitates the same positions that the tibia and femur are in during the jerk test. This same sensation of shifting is often felt during this test.

With the detailed history of mechanism of injury, examination by palpation, observation, and ligamentous exam, the physician should have a good idea of the status of the athlete's injured knee. As stated before, once a test is noted to be positive either by the trainer or by the team physician on the field, it must be considered positive until proven otherwise. This is done later by the orthopaedist with an examination under anesthesia if felt necessary. The golden period of examination is within the first 15 minutes on the sideline. Once it has been determined that there is a ligamentous injury, the knee should be immediately splinted, and the player should be placed on crutches and taken to an emergency room for roentgenographic examination and orthopaedic consultation if necessary.

Discussion

With today's interest in sports medicine, athletes are getting better care than they ever have before. Knowledge of the knee joint in particular has made great strides in the past several years. However, the



Figure 6a. Cross-over test standing.



Figure 6b. Cross-over test squatting.

best results for ligamentous injuries are still obtained when a repair can be accomplished on an acute injury. An acute injury is very hard to define. However, if the ligamentous injury can be repaired within the first 10 days after the injury, it has an excellent chance of doing quite well. The team physician, whether he be a general practitioner or an orthopaedic surgeon, should take the responsibility of being available to the team trainer and the athletes and have a working knowledge of the knee examination. If the team physician can master the above illustrated tests and get a good feeling of the knee examination during the pre-season physical, he will be in "good shape" for the football season. He should be able to diagnose any knee injury or at least recognize the need for further evaluation. It is the right of these athletes to have adequate care on the sidelines.

Summary

1. The team physician has the responsibility of availability to the athlete and adequate knowledge of knee injuries.

2. Close communication between team physician, orthopaedic surgeon, and team trainer are beneficial.

3. Immediate examination on the field is the best examination because muscle spasm has not yet begun.

4. Oftentimes massive ligamentous injuries will have no swelling.

5. Mastery of the simple tests illustrated here will enable the physician to make accurate diagnosis on acute knee injuries.

6. *Acute ligamentous injuries need to be repaired surgically within 10 days.* ★★★

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Bibliography

1. Torg, J. S.: Clinical diagnosis of anterior cruciate ligament instability in athletes. AJSM 4:2, 1976, pp. 84-88.
2. Hughston, J. C., Andrews, J. R., Cross, M. J. and Moschi, Arnaldo: Classification of knee ligament instabilities. Part I, The medical compartment and cruciate ligaments. JBJS 58:2, 1976, pp. 159-172.
3. Hughston, J. C., Andrews, J. R., Cross, M. J., and Moschi, Arnaldo: Classification of knee ligament instabilities. Part II, The lateral compartment. JBJS 58:2, 1976, pp. 173-179.

Complications Resulting from Cesarean Section

G. RODNEY MEEKS, M.D., Moderator

DR. MEEKS: The cesarean section rate now is approaching 15%-20% in most hospitals. Although most obstetricians feel that this cesarean section rate has produced overall healthier babies, the tradeoff has been more complications for the mothers. Today we review complications that arise in patients who undergo major surgical procedures.

DR. LEHMAN: K. H. is a 20-year-old, black woman, gravida 1, para 0, who is in active labor at 42 weeks' gestation. Her prenatal course was entirely normal.

At the time of admission, she had been in active labor for five hours and membranes had been ruptured for two hours. Her cervix was 5 cm dilated and 90% effaced. The fetal vertex was at station S-2 in the ROP position. Clinical evaluation of the pelvis showed that it was borderline size. The fundal height was 35 cm above the symphysis and the estimated fetal weight was 3500 grams. The remainder of the physical examination was normal. Her admission hematocrit was 37% and her admission urinalysis was normal.

She was observed in active labor over the next five hours. She had no further dilatation or descent and the fetal vertex developed marked molding. How would the panel manage this patient now?

DR. HOLLIS: You have described cephalopelvic disproportion. Some people would not make the diagnosis without x-ray pelvimetry but I believe that you should have enough digital capability to make the decision. I would proceed to cesarean section.

From the Department of Obstetrics and Gynecology, University Medical Center, Jackson, MS.

Panelists: Ross F. Bass, M.D. of Jackson, Richard S. Hollis, M.D. of Amory, and E. J. Price, Jr., M.D., of McComb. Thomas Lehman, M.D., presents the case.

DR. BASS: I hardly ever order x-ray pelvimetry. The best pelvimetry is a trial of labor to see if the fetal vertex will pass through the pelvis with no difficulty. I would proceed to cesarean section.

DR. LEHMAN: A primary low segment transverse cesarean section was performed with the delivery of a living female infant who weighed 3150 grams and had Apgar scores 7/8. Thick meconium was noted, but no evidence of intrauterine infection was noted even though membranes had been ruptured for a total of nine hours.

DR. BASS: I am surprised the meconium stained fluid was not noticed earlier. Thick meconium staining often indicates fetal distress, and I wonder if this was not demonstrated on the electronic monitor.

DR. LEHMAN: The external monitor showed no evidence of fetal distress and meconium was not seen prior to the time of delivery.

DR. HOLLIS: Certainly internal monitoring is better than external monitoring, and internal monitoring might have picked up evidence of fetal distress which could not be demonstrated on external monitoring. One must remember meconium staining does not always mean fetal distress. I am not surprised the meconium fluid was not noticed earlier. Everyone has seen a patient with a borderline pelvis and cephalopelvic disproportion where the fetal head is

wedged into the pelvis and no fluid can leak around the fetal head into the vagina.

DR. LEHMAN: Would you use prophylactic antibiotics in this patient?

DR. PRICE: I have used very little true prophylactic antibiotics, and I am very selective. If there has been extensive manipulation, unusual trauma, or prolonged rupture of membranes I would start antibiotics as soon as the cord is clamped. Usually I continue them for several days until I know that the patient will remain afebrile.

DR. BASS: I try to base antibiotic therapy on the time that the membranes have been ruptured, but no one knows how long it takes for the amnion to become infected. It has been only recently that I have given true prophylactic antibiotics, i.e. only two or three doses.

DR. HOLLIS: If I have a patient who comes in with premature ruptured membranes, I routinely insert a sterile speculum and take cultures of the cervix. Also, I culture the fetal and maternal sides of the placenta at the time of section. Internal monitoring puts patients at greater risk of infection in my experience.

DR. LEHMAN: What antibiotics would you select for prophylaxis?

DR. PRICE: Ordinarily, I would select cephalosporins.

DR. BASS: Some work now shows that ampicillin might be the drug of choice but cephalosporins are customarily used. I have a fair amount of experience with cefamandole.

DR. HOLLIS: I have continued with the cephalosporins using one dose prior to making the incision and then a dose every six hours for 24 hours.

DR. LEHMAN: Antibiotics were not started. On the day following surgery, the patient spiked a fever to 102° F and her hematocrit was 28%. What should be included in the differential?

DR. PRICE: Atelectasis is the most common cause of immediate post-op fever. One must also consider sepsis from the urinary tract. Typically, infection of the surgical site would be two to three days later. However, one must consider endometritis because of the thick meconium and rupture of membranes.

DR. BASS: An additional cause of fever is minimal amniotic fluid embolus.

DR. HOLLIS: One should consider all infectious etiologies, although surgery or complications of surgery are sources of fever. I recall patients who have had acute parotiditis, acute thyroiditis, and mastitis.

DR. LEHMAN: Physical exam revealed a copious foul smelling vaginal discharge. The uterus was extremely tender but no masses or induration could be palpated. The abdomen was distended and hyperresonant, and bowel sounds were absent. A diagnosis of postpartum endometritis was made. What antibiotics would be appropriate here?

DR. BASS: I would start clindamycin and gentamicin. Since she is distended, I would also insert a nasogastric tube.

DR. HOLLIS: I would order a flat and upright x-ray of the abdomen to evaluate the bowel gas patterns first.

DR. LEHMAN: Clindamycin and gentamicin were begun. The cultures of the urine and uterus that were taken prior to antibiotic therapy showed *Proteus mirabalis*. She began vomiting copious quantities of green bilious fluid and complaining of abdominal distention. What should be included in the differential? What might you expect to see on the abdominal films?

DR. PRICE: One must consider paralytic ileus perforation or intestinal obstruction. The cause could be peritonitis secondary to her infection. If I were really concerned about a bowel obstruction I would insert a Miller-Abott tube and consult a general surgeon.

DR. HOLLIS: Ileus, peritonitis, bowel obstruction, bladder flap hematoma, and abscess must be in the differential. I think you will find distended loops of gut with air-fluid levels.

DR. LEHMAN: The x-rays did show air-fluid levels. While trying to insert the nasogastric tube, the patient began to retch violently and copious quantities of green tinged fluid poured from her wound. Several sutures were removed and the incision explored in a sterile fashion using a cotton tipped applicator. What is your diagnosis and next step in management?

DR. BASS: You have a defect in the abdominal wall until proven otherwise. Wound infection or small bowel fistula is a possibility. However, the fluid described is not characteristic of either. Many times I have seen bowel protrude through the wound when one starts probing.

DR. HOLLIS: I would be extremely apprehensive about taking sutures out of a patient like this on the ward. I would take her to the operating room before I removed any sutures because an uncontrolled evisceration on the ward is extremely dangerous. I would then remove the sutures and explore the wound. Also, I am concerned about intraabdominal abcesses, particularly the subdiaphragmatic and subhepatic spaces.

DR. PRICE: I would take her to the operating room.

DR. LEHMAN: She was then taken to the operating room for exploration. An accumulation of pus was

found in the subcutaneous tissue. The upper one-third of the fascia was completely separated as was the underlying portion of peritoneum. The incision was completely reopened and the abdomen explored. The bowel was examined and no injury was noted. The uterus was unremarkable with the exception of a small accumulation of pus underneath the bladder flap. What would you do now?

Dr. Hollis: Generally, the initial sutures have pulled through the fascia, which is very friable, and I have difficulty getting the sutures to hold. I would close the wound primarily using interrupted permanent sutures and retention sutures. I would place a drain above and below the fascia, and at the bladder flap.

Dr. Bass: I would not use retention sutures unless she were obese. However, unless her general condition improves, she very likely will dehisce again. If I did use retentions, I probably would leave the wound open so that I could irrigate the wound with hydrogen peroxide solution.

Dr. Price: I would use retentions for any dehiscence. My choice would be nylon or wire. I would place them in a through and through fashion and then irrigate the entire incision.

Dr. Lehman: Would you use drains?

Dr. Bass: I would use penrose drains and bring them out through separate stab wound incisions.

Dr. Price: I would use penrose drains too; however, some people have been getting good results using the closed suction systems.

Dr. Lehman: What steps in postoperative management are important?

Dr. Hollis: The general management is important. The electrolytes must be balanced. An adequate fluid intake and an adequate urine output must be maintained. With a hematocrit of 28% and an infection in the wound, I would consider blood replacement. The hematocrit should be kept above 30% to aid healing. The nasogastric tube should remain in place until she begins passing flatus. The retention sutures should remain in at least 14 days.

Dr. Price: I agree that once the nasogastric tube is down you should leave it until she begins passing flatus. I would leave the retentions in for three to four weeks.

Dr. Lehman: Would all of you continue her antibiotic therapy?

Dr. Price: Yes.

Dr. Lehman: The patient did well. Her nasogastric tube was removed on the fifth postoperative day when she began passing flatus. She was started on clear liquids and progressed to a regular diet. On the tenth postoperative day, which was 12 days after her cesarean section, she was discharged.

Dr. Meeks: On behalf of the Department and the University I would like to express our appreciation to these gentlemen for taking time from their busy practices to share their experiences and clinical expertise. Thank you. ★★★

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Acknowledgement

The Department is grateful to Drs. John E. Lindley of Meridian, Purves J. McLaurin, Jr., of Oxford, and Thomas R. Singley of Pascagoula, for their contributions in establishing these clinical case management discussions, and to Drs. Oney C. Raines, III, of Gulfport, James E. Royals of Jackson, and Glenn Wegener of Clarksdale for their participation on earlier panels.

Radiologic Seminar CCXVI: Hepatobiliary Imaging

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THE ADVENT OF technetium 99M labeled acetanilide iminodiacetic acid (99M Tc-IDA) analogues has enabled us to more adequately evaluate the functional integrity of the biliary pathways.[1]

Approximately 85% of 99M Tc-HIDA, an analogue of the IDA compounds, is taken up by the hepatocytes of the liver and excreted unconjugated into the biliary system. About 15% is excreted by the kidneys within the first ten minutes after an intravenous injection. Normally the liver activity peaks within 5 to 10 minutes with the common bile duct, gallbladder, and duodenum being imaged between 15 to 30 minutes. The upper limit of normal for visualization of the gallbladder is about one hour. There is usually marked clearing (washout) of the isotope activity from the liver within two hours.[2]

The protocol in our lab consists of giving intravenously a 5 mci to 9 mci dose of 99M Tc-disofenin, another IDA analogue. Immediate post-injection anterior, posterior, and right lateral views of the liver are obtained. Interval images are obtained at 10 to 15 minutes to include the inferior one half of the liver, gallbladder, and adjacent small bowel regions. Imaging is continued through one hour or until gallbladder and bowel are visualized. Oblique and right lateral views are often helpful to differentiate gallbladder from bowel or bile ducts. The higher doses of isotope are given to jaundiced patients. Imaging times are varied for postoperative evaluation. Follow-up studies are obtained up to 24 hours for jaundice evaluation.

The advantages of this study are that it is a safe and simple procedure with no known complications or contraindications. It may be performed in the jaundiced patient. The patient's habitus and the presence of bowel gas and feces do not pose technical difficulties. No special patient preparation is required, although it is preferable to have an approximate two-hour fasting state.

Ultrasonography and computed tomography are quite helpful in evaluation of bile duct dilation and may directly identify the cause in obstructive jaundice secondary to stone or tumor. Cholecystography and IV cholangiography are also useful for evaluation of gallbladder function, gallstones, bile duct obstruction, or dilation. However, all of these studies have definite limitations in the evaluation of patients with acute right upper quadrant pain or jaundice.

It has been our recent practice to use ultrasonography and isotope biliary imaging as the screening procedures of choice in the evaluation of patients suspected of having acute cholecystitis.

Visualization of the gallbladder on the isotope images within one hour established patency of the cystic duct. This virtually excludes the diagnosis of acute cholecystitis since the cause is obstruction of the cystic duct in about 98% of cases.[3] Nonvisualization of the gallbladder with demonstration of the common bile duct and bowel is regarded a strong indication of actue cholecystitis. However, some cases of nonvisualization may actually represent chronic cholecystitis. The combined utilization of other studies, especially ultrasonography, where actue cholecystitis is suspected, usually makes this a moot point. Both the specificity and sensitivity of this study are believed to be greater than 95% in the diagnosis of acute cholecystitis.

Biliary scanning with 99M Tc-IDA scanning has also been shown to be highly accurate in differentiating acute cholecystitis from acute pancreatitis with an accuracy of 87% compared to about 50% accuracy reported for IVC and oral cholecystography.[4]

Hepatobiliary surgical procedures may also be evaluated postoperatively by serial 99M Tc-IDA imaging to disclose many of the related complications such as obstruction, bile leakage, abnormal flow patterns, or gastric reflux.[3]

Biliary imaging in conjunction with ultrasonography and computer tomography is useful in the differential diagnosis of jaundice.[5]

Figure 1 consists of three images taken from a normal study.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Medical Center, Jackson, MS.



Figure 1. Serial images of normal hepatobiliary study with labeled line drawing of one-hour image: A — gallbladder; B — hepatic ducts; C — common bile duct; D — small bowel.

(1) Note the normal homogenous distribution of activity throughout the liver on the 1- to 2-minute post-injection anterior image. This is comparable to a 99M Tc-sulfur colloid image and may actually be used for the sulfur colloid study.

(2) On the 15-minute image the biliary ducts and gallbladder are visualized. Note the absence of activity in the right hepatic duct branch. This is because of the more posterior location of this structure and thus poor visualization on this anterior image.

(3) The one-hour delayed image now reveals activity in the bowel in addition to persistent visualization of the bile ducts. There is a progressive accumulation of isotope activity in the gallbladder. Note the decreasing amount of activity in the liver (washout).

Note: These agents are currently used only under a

Phase III investigational permit in this country awaiting FDA approval for routine use. ★★★

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References

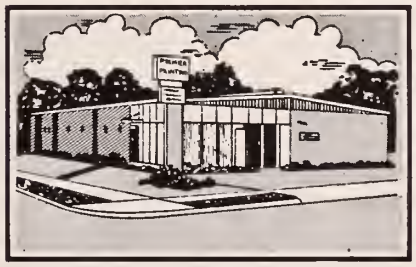
1. Harvey, E., Loberg, M. and Cooper, M.: Tc-99M-HIDA: A new radiopharmaceutical for hepatobiliary imaging (abstr.). J. Nud. Med. 16:533, June 1975.
2. Weisman, H. S., Frank, M. S., Bernstein, L. H. et al: Rapid and accurate diagnosis of acute cholecystitis with 99M Tc-HIDA cholescintigraphy. AJR 132:523-528, April 1979.
3. Rosenthall, L.: An update on radionuclide imaging in hepatobiliary disease. JAMA, Vol. 245, No. 20, 2065-2068, May 22/29, 1981.
4. Fonseca, C., Greenberg, D., Rosenthall, L. et al: 99M Tc-IDA imaging in the differential diagnosis of acute cholecystitis and acute pancreatitis. Radiology 130:525-527, February 1979.
5. Rosenthall, L., Shaffer, E. A., Lisbona, R. and Pare, P.: Diagnosis of hepatobiliary disease by 99M Tc-HIDA cholescintigraphy. Radiology 126:467-474, February 1978.

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The President Speaking

Highlights of Upcoming Activities

R. FASER TRIPLETT
Jackson, Mississippi

Continuing a tradition of holding its summer meeting with one of the local component medical societies, the Board of Trustees had a most productive meeting in late July in Meridian. This gives the Board an excellent opportunity to make themselves available to the members for frank and open discussions of issues that concern the membership and hopefully makes the Board more responsive to those they represent. The Board most appreciates the warm welcome and hospitality afforded by the East Mississippi Medical Society.

For a more complete report of the business addressed by the Board, I call your attention to a summary elsewhere in this issue of the JOURNAL. However, I would like to highlight a few items of major interest and importance.

Later this month Dr. Ed Hill of Hollandale, Dr. Paul Moore of Pascagoula and I will meet with our congressional delegation in Washington to discuss the Medicare two fee areas in Mississippi and seek solutions to the inequities created by these separate areas.

An MSMA leadership conference will be conducted in March 1982 in Jackson. I hope many of you will avail yourself of this opportunity to become more knowledgeable on current issues of extreme importance to our profession. This will also give you an opportunity to voice your views on society affairs. The success of this conference is dependent on your participation. Unfortunately, some well planned conferences on vital issues have failed in the past because of indifference and lack of interest. Our past president observed recently in this JOURNAL that we must become more involved at the local component level. Conferences such as this go a long way toward that end.

Finally, I would like to alert you to look for a brochure later presenting the MSMA legislative program for the 1982 session. It is most important for each of you to acquaint yourself with the MSMA position and to make certain that your legislator knows of your individual interest in these positions. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 9
SEPTEMBER 1981

On Spending Le$$ And Making Change

President Reagan's victory on July 29, ie, the passage of his tax bill, will give supply side economics, or Reaganomics, a chance to be tried. Reduction in expenditures must be made. How the proposed cuts in federal spending will affect the health care field remains to be seen, but as with all such changes, adjustments will have to be made.

"No one who understands the basic economic facts of life which we face as a nation can dispute the magnitude of the problem before us. Our economy simply cannot support a spending growth rate that will ultimately bankrupt us and undercut our ability to provide any services at all to our people." So stated Richard Schweiker, secretary of Health and Human Resources.

Most of the proposed changes appear healthy and are, in some cases, long overdue. Making more block grants to the states and giving them more leeway in their utilization is in keeping with the President's basic philosophy and his commitment in seeking office. The phasing out of public health hospitals seems only proper. Hospital care for merchant seamen is no responsibility of the federal government.

The PSRO program is on the "hit list." Both Schweiker and Edward Brandt, Jr., the number one M.D. and assistant secretary to Schweiker, agree that it will be phased out. Many PSRO's have been ineffective, accomplishing little, while others have been very efficient and probably cost effective. It is interesting to note that, for the most part, physicians resent PSRO, but as they become more familiar with or actually participate in the program they become much more supportive.

As the states are given larger responsibility for public health care, there will be less need for federal monitoring, and it will become a concern at the state level. Rest assured that if public health care dollars are not reasonably monitored, abuses will soon become intolerable.

Before we condemn PSRO, let's remember the arbitrary manner of third party payors on occasion. Do we want to keep it with US, or leave it to THEM?

W. Moncure Dabney, M.D.
Editor

P.S. Since the above was written, it appears that PSRO has been granted, at least in part, a reprieve. States may be allowed 75% federal funding if they choose to apply. — W.M.D.

Congress Clears Health Budget

After a frantic burst of activity, Congress settled the budget reconciliation bill, voted on tax cuts, and departed for a vacation with much of its legislative work for the session behind it.

The Administration was delighted with the overall budget reconciliation compromise that pared spending next fiscal year by $37 billion. The Administration was forced to retreat on the two key health items — Medicaid and block grants — that had threatened to stall the huge conference negotiations on the House and Senate budget bills.

The five percent cap that the Administration wanted to impose on increased federal outlays for Medicaid next year was thrown out. The Senate had voted a nine percent cap, but the House had approved a formula decreasing federal payments over the next three years by three percent, two percent and one percent.

The conference compromise reduced projected costs by three percent, four percent the following fiscal year, and 4.5 percent the next year. Savings are estimated to be about $1 billion a year, about what the Administration sought.

A controversial Senate plan to drop the minimum federal contributions to states to 40 percent from the present 50 percent was a casualty of the conference.

A dozen larger states would have been especially hard hit.

State fears about the impact of the Administration's Medicaid cap were a major reason House Republicans decided not to fight earlier on the House floor for a health budget package following the Administration's recommendations. Instead, more liberal health provisions backed by the House Democratic leadership were adopted without resistance in order to assure House passage of the rest of the Republican budget substitute that was a triumph for the Administration.

Sen. Orrin Hatch (R-UT), Chairman of the Senate Labor and Human Resources Committee, made a determined fight to hold the line on the Administration's plan to put 26 categorical health programs into block grants to the states.

With his back against the wall and House conferees not budging, Hatch finally took the unusual step of asking the White House to endorse any concessions he might have to make. The clearance was granted and the impasse over block grants was broken.

The Administration had proposed to break the 26 programs that cost some $4 billion a year into two block grants, giving the states a free latitude to spend their allotments within the blocks.

The compromise calls for three block grants and for continued attachment of certain federal strings on all programs involved. The three blocks cover preventive health, health services and primary care.

The controversial family planning program would remain as a categorical program for three years during which time Health and Human Services (HHS) Secretary Richard Schweiker would make a study of the program.

The preventive health block grant would include home health programs, rodent control, fluoridation, health education, hypertension, emergency medical services, rape crisis centers and health incentive programs.

The health services block combines mental health and alcohol and drug abuse prevention.

The primary care block grant primarily covers community health centers.

Programs excluded from block grants include, in addition to family planning, venereal disease control, child immunization, tuberculosis control and migrant health programs.

However, two of the three block grants that emerged from conference were so limited as to be little more than categorical. Under the Health Services block grant, for example, states next year must allocate funds among mental health, alcohol and drug abuse programs as they have in the past. They can shift funds about by five percent the following year and 15 percent the next.

Under the agreement, the health planning program grants were allowed to continue but with cuts. States will be allowed to reduce the number of Health Systems Agencies, and the dollar triggers for certificate-of-need review were increased.

The Administration will be allowed to eliminate as many as 30 percent of the 187 Professional Standards Review Organization (PSRO) programs. The House bill would have permitted the President to kill the program within a few years.

Authority was given in the budget bill to phase out the Public Health Service Hospitals starting next fiscal year.

Programs reauthorized included Health Maintenance Organizations (HMOs), Health Statistics Center, Health Services Research Center, Health Care Technology Center and the National Library of Medicine. Federal funding under the HMO program will only be authorized to HMOs currently in the funding pipeline.

The budget bill cleared the way for C. Everett Koop, M.D., to become Surgeon General by removing the age limit for the job and the requirement that the nominee have experience within the PHS.

The existing adolescent pregnancy program was continued with a new program added for research on sexual chastity and for storefront and other operations to counsel on prevention of promiscuity, etc.

No major changes were made in Medicare, but a House provision was adopted to increase by $28 the amount patients must pay hospitals before the program picks up the expense. Rejected was a House proposal to require Medicare patients to pay $1 a day for each of the first 60 days of hospitalization.

114th Annual Session

May 2-6, 1982
Biloxi Hilton

Mark Your Calendar NOW

Board of Trustees Conducts Summer Meeting

MSMA's Board of Trustees held its regular summer meeting in Meridian in July at the invitation of the East Mississippi Medical Society.

Primary business coming before the Board included referrals from the recent meeting of MSMA's House of Delegates and ongoing activities of the association.

Acting on reports from the House of Delegates, the Board of Trustees scheduled a MSMA Leadership Conference in conjunction with its March 1982 regular meeting. The conference will address state health issues of concern to the medical profession. Component society officers and delegates will be invited to attend. The component societies will also be urged to send representatives to the AMA National Leadership Conference in Chicago in February.

The Board further directed studies of a dues increase and reorganization of the MSMA Annual Session, both of which were directed by the House of Delegates for presentation at the 1982 Annual Session.

Acting on other referrals from the House of Delegates, the Board endorsed a solicitation letter for tax deductible, voluntary contributions to support MSMA's disabled physicians' program which will be sent to all MSMA members in August. In another referral item of business, plans for recognizing MSMA's 125th Anniversary Year, which begins on December 15, 1981, were presented to the Board by a committee composed of the association's past presidents.

Actions by the House of Delegates on third party health programs led the Board to establish liaison committees to meet with insurance carriers in the state and Medicare officials in Washington. An early meeting will also be sought with the Governor to discuss the future of Medicaid and other state health programs.

Also acting on a report from the House of Delegates, the Board adopted a four-year Wednesday through Sunday meeting schedule for annual sessions of the association beginning in 1983. The 1982 annual session will be conducted May 2-6 in a Sunday through Thursday format as previously scheduled.

The Board further acted on a resolution adopted by the House of Delegates which would have the association support a program to remove drunken drivers from the roads and directed that publicity be given to the state's new DUI law and the risks and consequences to the public of driving under the influence of alcohol.

In other activities, the Board endorsed the association's support for the nomination and election of Dr. W. Lamar Weems as a member of the AMA Council on Medical Education. Dr. Weems presently serves as a delegate to the AMA.

A special committee of the Board gave a report on the current status and future plans for a Perinatal Center at the University Medical Center. The Board endorsed the association's continued support for the center and support for the alleviation of the current OB delivery situation at the UMC.

The Board heard a report on the assocation's 1982 legislative recommendations which includes support for legislation: (1) to establish standards for multiphasic health screening programs; (2) to strengthen the confidentiality of peer review proceedings; (3) to require child passenger restraint systems in automobiles; (4) to reduce malpractice claims; and (5) to increase the state per diem for charity patients in public hospitals.

The Board received a report on the association's group sponsored insurance programs conducted by an independent consulting firm which found that the programs were competitive and properly administered. The Board directed that the report be publicized in the JOURNAL MSMA.

In final action, the Board reviewed the current status of PSRO and actions by the AMA and MSMA House of Delegates opposing government directed peer review but supporting peer review directed by the medical profession through physician sponsored organizations. The Board acted to join with the Mississippi Foundation for Medical Care in seeking public, industry and third party endorsement in Mississippi for review of the quality and necessity of

medical services through a physician sponsored and directed program.

Attending the meeting were: R. Faser Triplett, M.D., Jackson, president; Sidney O. Graves, M.D., Natchez, president-elect; Paul H. Moore, M.D., Pascagoula, immediate past president; J. Elmer Nix, M.D., Jackson, secretary-treasurer; Whitman B. Johnson, M.D., Clarksdale, chairman; Ellis M. Moffitt, M.D., Jackson, vice chairman; W. Boyce White, M.D., Laurel, secretary; W. Joseph Burnett, M.D., Oxford; William C. Gates, M.D., Columbus; William B. Hunt, M.D., Grenada; James O. Manning, M.D., Jackson; George L. Arrington, M.D., Meridian; David R. Steckler, M.D., Natchez; Roy D. Duncan, M.D., Pascagoula; Carl G. Evers, M.D., Jackson, speaker, House of Delegates; James C. Waites, M.D., Laurel, vice speaker, House of Delegates; James O. Gilmore, Oxford, delegate to AMA; and W. Lamar Weems, M.D., Jackson, delegate to AMA.

MSMA Plans for 125th Anniversary

A committee composed of past presidents of the association and MSMA Auxiliary representatives is moving ahead with plans to recognize and commemorate MSMA's 125th Anniversary Year which will begin on December 15, 1981.

Tentative planning at this time calls for the December JOURNAL MSMA to be published as an official anniversary issue containing articles about medical organization and activities in the state. Articles have been solicited from the association's component societies, the auxiliary, the University of Mississippi School of Medicine and the Mississippi State Board of Health. Additionally, there will be other articles and pictures noting significant medical events in the state.

The association's Board of Trustees plans to conduct its regular fall meeting on December 15, 1981 and events are being planned to recognize the association's birthday at that time.

Additionally, planning is in progress at this time to participate in the development and location of a "country doctor's office" at the Mississippi Agricultural and Industrial Museum being constructed in Jackson.

Next year's annual session is also being considered as a 125th Anniversary meeting with a history of medicine exhibit solicited from the membership and other planned events to recognize and celebrate the occasion.

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Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:
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Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, nonpenicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anophylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY. Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulanephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

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Chronic Infections	500 mg q i.d.	100 mg/kg/day q i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q i.d.	100 mg/kg/day

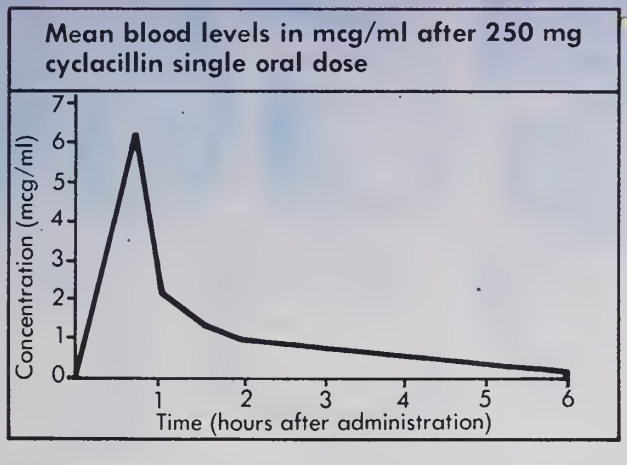
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*Based on T^{a} ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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†Due to susceptible organisms.

See important information on facing page.

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Five MSMA Auxiliary officers attended the AMA Auxiliary's annual meeting in Chicago in June. Seated from left to right are: Mrs. James Martin of Ocean Springs, president-elect; Mrs. John Estess of Hollandale, president; and Mrs. Curtis Roberts of Brandon, immediate past president. Standing are Mrs. Stanley Hartness of Kosciusko, second vice president, and Mrs. Ed Hill of Hollandale, director, MSMA and AMA auxiliaries. Auxiliary chapters throughout the state will place special emphasis on health education projects during the next year.

MSMA Supports New DUI Law

Mississippi's new "driving under the influence" law went into effect July 1. Based on action of MSMA's House of Delegates, the association will be closely watching the effects of the law in reducing fatalities from DUI on the state's highways.

The DUI statute, which the association supported for two years prior to its passage by the 1981 Mississippi Legislature, reduced blood alcohol content for DUI to .10 percent and strengthened penalties for second and third time convictions.

Mississippi Commissioner of Public Safety Sidney Berry has called for strict enforcement of the new law. In Jackson a special roving DUI police unit has been established.

The association's House of Delegates at its recent annual session adopted a resolution from Singing River Medical Society calling for removal of drunken drivers from the state's highways as a priority public health goal. A health needs study by the association in 1979 cited 400 highway deaths in Mississippi in 1977 as alcohol related.

Dr. Conerly Named UMC's Assistant Vice Chancellor

Dr. Albert Wallace Conerly, Sr., has been named assistant vice chancellor at the University of Mississippi Medical Center.

His July 16 appointment was announced following approval of the Board of Trustees, State Institutions of Higher Learning. Dr. Conerly is also an assistant professor of medicine at the Medical Center, professor and medical director of the Department of Respiratory Therapy in the School of Health Related Professions, and, since 1979, director of the UMC Division of Continuing Health Professional Education.

Dr. Conerly is an honor graduate of Millsaps College and earned the M.D. at Tulane University School of Medicine.

The Tylertown native has served as commander of the 3575th United States Air Force Hospital at Vance Air Force Base in Oklahoma and director of the Aerospace Medicine Division of the 3550th U. S. Air Force Hospital at Moody Air Force Base in Georgia. Recipient of the Flight Surgeon-of-the-Year Award and a Commendation Medal, Dr. Conerly left the Air Force with the rank of major in 1966.

A general practitioner in the Jackson area for four years, he completed a residency in internal medicine at the Medical Center and joined the faculty in 1973.

He held a fellowship in cardiology at the Alton Ochsner Medical Foundation and Ochsner Foundation Hospital in New Orleans and was a Mississippi Lung Association fellow in respiratory diseases at UMC. His professional affiliations include membership in the American Thoracic Society, the American College of Chest Physicians and the American College of Physicians.

Dr. Conerly has served as a senior examiner on the National Board of Respiratory Therapy and has represented the American Thoracic Society on the Board of Trustees of the National Board of Respiratory Therapy. He also serves as medical advisor to the Mississippi Society, American Association of Respiratory Therapy.

DOCTORS HELPING DOCTORS

Voluntary, tax deductible contributions to MSMA's Disabled Doctors Program may be made to the Caduceus Club of Mississippi. P.O. Box 5229, Jackson, MS 39216.

RECOLLECTIONS

The September 1961 issue of JOURNAL MSMA carried news of a survey conducted by *Good Housekeeping* magazine. The statement that "most people view their own family physician with warm gratitude and deep admiration" summarized the opinion poll's results. Respondents to the 1961 survey said: doctors charge reasonable fees (81 percent); know their profession (86 percent); and are considerate (89 percent). Only two percent said their doctor was as interested in money as in patient health.

Also in that issue was the announcement of the appointment of Dr. W. Moncure Dabney as editor of JOURNAL MSMA.

News from UMC included the formation of the Special Birth Defects Treatment Center, established in cooperation with the March of Dimes Foundation, and the receipt of bids for construction of a $3.15 million, eight-story research wing at the medical school.

In his "President's Page," Dr. Lawrence W. Long urged involvement by MSMA members in the upcoming legislative session by pointing out doctors' responsibilities to seek "just and equitable laws with respect to health and medical care."

Drs. George E. Twente of Jackson and H. H. McClanahan, Jr., of Columbus had returned from Washington where they testified before the House Committee on Ways and Means in formal hearings on the King-Anderson bills. The JOURNAL carried the full text of their testimony, a summary of private health care progress in Mississippi.



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POSTGRADUATE CALENDAR

Oct. 6, 1981

Mississippi Thoracic Society Meeting, Scientific Session and Annual Boswell Lecture
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, Pulmonary Division, the Department of Radiology, the Medical Center Division of Continuing Health Professional Education in cooperation with the Mississippi Lung Association and the Mississippi Thoracic Society.

Coordinator: Robert P. Henderson, M.D., clinical instructor in radiology, University Medical Center.

Dr. Arl Van Moore, assistant professor of radiology at Duke University Medical Center, will present the annual Boswell Lecture, established in 1971 to honor the late Dr. Henry Boswell who served as first superintendent of the Mississippi State Sanatorium. Fee: $10. Credit: 5.75 credit hours (.57 CEU), Category 1 of the AMA Physician's Recognition Award. AAFP credit applied for.

Oct. 14-17, 1981

Family Practice Update
Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine, the Medical Center Division of Continuing Health Professional Education and the Mississippi Academy of Family Physicians.

Coordinators: Robert C. Forbes, M.D., and Robert F. Willis, M.D., assistant professors of family medicine, University Medical Center.

This annual review for primary care physicians will feature lectures on practice-oriented topics. Brief lectures followed by question and answer periods will provide an opportunity to explore problems encountered in day-to-day care of office and hospital patients. Fee: $125. Credit: 21.5 credit hours (2.1 CEU), Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

Medico-Legal Brief

Restrictive Covenant Cannot Be Enforced

A surgeon's former employer could not enforce a restrictive covenant against the surgeon when he terminated his employment, a Wisconsin appellate court ruled.

The surgeon had signed an agreement restricting him from practicing as a physician in the county for nine months after his termination of employment. His employer was a surgical consultants group. A trial court awarded damages to the employer for breach of the restrictive covenant in the employment contract.

On appeal, the physician contended that restricting him from practicing as a physician was not reasonably necessary for the protection of the employer, whose practice was limited to surgery. The appellate court agreed, saying that the employer failed to offer any evidence to prove its reasonable need to restrict him from practicing as a physician.

The court said a restrictive covenant was enforceable only if the restraints imposed were reasonably necessary for the employer's protection. The surgical group had the burden of proving the reasonably necessity of a restrictive covenant, the court said. The surgical group acquired a protectible right to reasonably prevent competition by the physician since it provided him with referral contracts and aided in developing his reputation among area physicians.

The surgical group offered no evidence that the physician's practice, other than surgery, should compete with its surgical practice. There was also no evidence that there was a justifiable need to restrain his noncompetitive practice of medicine, the appellate court ruled. The trial court's decision was reversed. — *Geocaris v. Surgical Consultants, Ltd.*, 302 N.W.2d 76 (Wis.Ct. of App., Jan. 27, 1981)

NEW MEMBERS

Dohn, Donald F., Pascagoula. Born Buffalo, NY, Aug. 16, 1925; M.D., State University of New York at Buffalo, School of Medicine, 1952; interned Buffalo General Hospital, one year; general surgery residency, Cleveland Clinic Hospital, Cleveland, OH, 1953-54; neurosurgery residency, same, 1954-58; elected by Singing River Medical Society.

HANKINS, MELISSA, Greenville. Born Raleigh, MS, Dec. 30, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned University of Texas, San Antonio, one year; pediatric residency, same, 1978-81, anesthesiology residency, same, 1979-81; elected by Delta Medical Society.

HARMAN, FRANCIS EDWARD, JR., Meridian. Born Memphis, TN, May 4, 1951; M.D., University of Tennessee College of Medicine, Memphis, 1977; interned University of Tennessee Memorial Hospital, Knoxville, one year; internal medicine residency, U. S. Navy, 1978-81; elected by East Mississippi Medical Society.

JACKSON, GARY HOWARD, Greenville. Born Laurel, MS, April 20, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University of Texas, San Antonio, one year; orthopedic surgery residency, same, 1977-81; elected by Delta Medical Society.

MCLAURIN, EUGENE BRAMLETT, Amory. Born Oxford, MS, Dec. 26, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned UMC, Jackson, one year; ophthalmology residency, Oakland Naval Hospital, Oakland, CA, 1977-80; elected by Northeast Mississippi Medical Society.

NIEVAS, HUGO CARLOS, Gulfport. Born Argentina, Dec. 28, 1940; M.D., Cordoba University School of Medicine, Argentina, 1968; interned Englewood Hospital, Englewood, NJ, one year; medicine residency, V. A. Hospital, New Orleans, 1972-75; cardiology residency, same, 1975-77; elected by Coast Counties Medical Society.

SATERFIEL, JAMES LOUIS, JR., Jackson. Born Monroe, LA, June 5, 1951; M.D., Louisiana State University School of Medicine, Shreveport, 1976; interned Confederate Memorial Hospital, Shreveport, one year; radiology residency, Baptist Memorial Hospital, Memphis, 1977-80; elected by Central Medical Society.

SIMPSON, C. L., Houston. Born Albemarle, NC, July 21, 1941; M.D., Bowman Gray School of Medicine, Durham, NC, 1966; interned North Carolina Baptist Hospital, Winston-Salem, one year; general surgery residency, Bexar County Hospital, San Antonio, TX, 1969-73; elected by Northeast Mississippi Medical Society.

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Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruntic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

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Morris Plains, NJ 07950 USA

PERSONALS

THOMAS K. BILLUPS has associated with the Surgery Clinic of Tupelo, 607 Garfield Street, for the practice of general and vascular surgery.

CHARLES N. CRENSHAW, JR. of Newton announces the association of CHARLES N. CRENSHAW, III, for the practice of family medicine.

JOHN K. DRAKE announces the opening of his office for the practice of orthopedic surgery at 15 Marks Road in Ocean Springs.

CARL R. HALE of Hattiesburg and CLIFTON L. HESTER, JR., of Clinton have been named fellows of the American College of Radiology.

FRANK HARMAN has associated with the Meridian Family Practice Clinic.

STEPHEN H. HINDMAN of Jackson has associated with Cardiovascular Associates, P.A., 302 Medical Plaza, for the practice of cardiology.

EDWIN H. HOLMES has associated with Meridian Medical Associates, P.A., for the practice of internal medicine and pulmonary medicine.

PHIL A. HOOKER announces the opening of his office for the practice of dermatology and dermatologic surgery at 201 East Jordan Avenue in West Point.

WILLIAM C. HOPPER, JR. of Gulfport presented a paper at the First International Congress of the Orthopaedic Nursing Association in Dallas and presented two papers at the Hoke-Kite Pediatric Orthopaedic Seminar in Atlanta.

GARY H. JACKSON has opened his office for the practice of orthopaedic surgery and sports medicine at 1421 East Union Street in Greenville.

JOHN JACKSON of UMC spoke at a meeting of the Mississippi Association for Retarded Citizens in Ellisville in July.

EDWARD THOMAS JAMES, JR., has opened his office for the practice of orthopaedic surgery at Crane Ridge Office Plaza, 2660 Ridgewood Road in Jackson.

ALTON B. JAMES has associated with Internal Medicine Associates of Oxford.

JAMES H. JOHNSTON, III, and JAMES Q. SONES, II, of Jackson announce the formation of Gastrointestinal Associates, P.A., located at 500-B East Woodrow Wilson, and the association of BILLY W. LONG for the practice of gastroenterology.

RONALD S. KENT has joined the staff of the Pediatric Clinic, P.A., in Hattiesburg.

THOMAS W. LEHMAN has associated with Woman's Clinic, P.A., in Gulfport for the practice of obstetrics and gynecology.

JOHN DAVID MCBRAYER has associated with Internal Medical Associates, 425 Hospital Drive in Columbus, for the practice of internal medicine.

R. BRYANT MCCRARY has associated with Gulf Coast Pediatric Clinic, 0450 Pass Road in Gulfport, for the practice of pediatrics.

EDWARD NORTH was guest speaker at a recent meeting of the Magnolia Ladies Civitan Club of Jackson.

JAMES A. O'DONNELL has associated with the Laurel Pediatric Clinic, P.A., and the Waynesboro Pediatric Clinic for the practice of pediatric and adolescent medicine.

MILTON L. ROBY has opened his office for the general practice of medicine at 140 Jefferson Davis Boulevard in Natchez.

DOUGLAS WESLEY ROUSE, JR. has associated with the Hattiesburg Clinic, P.A., for the practice of orthopaedic surgery.

The Street Clinic of Vicksburg announces the association of DEBBIE SMITH for the practice of pediatrics and WAYNE M. PITRE for the practice of dermatology.

DAVID L. SPENCER has associated with the Robinson-Lane Surgical Clinic, P.A., Doctors' Plaza, Suite 206, in Pascagoula.

CLIFFORD TILLMAN of Natchez announces the association of CLIFFORD RANDOLPH TILLMAN for the practice of gastroenterology.

RICHARD M. VISE of Meridian has been certified by the American Board of Urology.

WILLIAM A. WHITEHEAD has associated with the Hattiesburg Clinic for the practice of general, thoracic and vascular surgery.

CHRIS E. WIGGINS of Pascagoula announces the relocation of his office for the practice of orthopaedic surgery to Suite 103, Doctors' Plaza Building.

When anorectal fires cool...

Continue therapy with

Anusol®

Suppositories/Ointment

to help maintain relief of hemorrhoidal or other anorectal symptoms

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Soothing, cooling

Tucks®

Premoistened hemorrhoidal/vaginal pads

for temporary relief of occasional external anorectal itching/burning and regular hygienic care.

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DEATHS

Alexander, Byron. Jackson. Born Lake County, TN, June 28, 1902; M.D., University of Tennessee College of Medicine, Knoxville, 1926; interned Memphis General Hospital, one year; Emeritus member of MSMA and AMA; died July 26, 1981, age 79.

Benoist, Edwin E., Natchez. Born Natchez, MS, Dec. 18, 1891; M.D., Tulane University School of Medicine, New Orleans, 1916; interned, one year, New York City; died July 4, 1981, age 89.

Broadus, Lloyd Z., Purvis. Born Purvis, MS, Feb. 6, 1924; M.D., University of Utah College of Medicine, Salt Lake City, 1947; interned Salt Lake General Hospital, Salt Lake City, 6 months; died July 7, 1981, age 57.

Kimbrough, George T., Hattiesburg. Born Nov. 21, 1928; M.D., Emory University School of Medicine, Atlanta, 1957; interned University Hospital and Hillman Clinic, Birmingham, AL, one year; pediatric residency, same, 1958-59; pediatric residency, University Medical Center, Jackson, MS, 1959-60; died July 1, 1981, age 52.

UMC Announces Faculty Appointments

The University of Mississippi Medical Center has added 14 to the School of Medicine and centerwide faculties.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Mary Pat Hemstreet joined the faculty as an associate professor of pediatrics. Named new assistant professors are Dr. Franklyn David Dornfest, family medicine; Dr. G. Howard Freeman, psychiatry and human behavior; Dr. Michael H. LeBlanc, pediatrics (newborn medicine); Dr. James Nello Martin, obstetrics and gynecology; Dr. David Walsh, preventive medicine; and Dr. James C. Lynch, anatomy.

Joining the faculty as instructors are Dr. John Philip Foster and Dr. Robert Eugene Smith, family medicine; Dr. Julia Sherwood and Brenda Sumrall, pediatrics; Dr. Tawfig Khansur, medicine; Dr. Ryo Soda, medicine (research); and Dr. Cyrill D'Cruz, pathology.

Dr. Hemstreet had been associate professor of pediatrics, head of the pediatric allergy division and director of the Allergy-Immunology Fellowship Program at the University of Alabama. A B.S. graduate of Pennsylvania State University, she earned the M.D. at Temple University Medical School, interned at the University of Oklahoma Medical Center and took residencies at Oklahoma and Duke University Medical Center.

A lecturer in the general practice unit at the University of Cape Town since 1978, Dr. Dornfest is former chairman of the Cape of Good Hope Region of the postgraduate education subcommittee at the College of Medicine of South Africa. He was in private practice in Milnerton, Cape Town, from 1968-1980.

Dr. Freeman earned the B.S. degree at the University of Southern Mississippi, the Master of Divinity degree at Emory University and the M.D. degree at the University of Mississippi Medical Center. He completed residencies at Emory and at UMC. Dr. Freeman had been in private practice of psychiatry in Meridian and a psychiatry consultant to the mental retardation facility at Whitfield.

Dr. LeBlanc earned the B.S. at Auburn University and the M.D. at the University of Alabama School of Medicine. He took residency training at the Children's Hospital Medical Center in Cincinnati. He held a fellowship at the University of Cincinnati College of Medicine, where he was 1981 NIH postdoctoral research fellow.

Dr. Martin comes to UMC from Woman's Hospital at the University of Michigan Medical Center where he was director of the antenatal diagnostic unit and the division of maternal and fetal medicine and fellowship program, obstetrics services chief and director and chief of the obstetrics intensive care and delivery unit. He earned the B.S. at Wake Forest, the M.D. at the University of North Carolina School of Medicine and took residency training at North Carolina Memorial Hospital. He held fellowships at Karolinska Hospital in Stockholm and at the University of Texas Health Sciences Center.

Dr. Lynch, a B.A. graduate of the University of Missouri, earned the M.A. in physiological psychology and the Ph.D. in neurological sciences at Stanford University and held a postdoctoral fellowship at the Johns Hopkins University School of Medicine. He had been assistant professor of physiology and neurology at the Mayo Medical School since 1976. Dr. Walsh, a B.S. graduate of Providence College, earned the Ph.D. and Ph.C. degrees at the University of Washington.



The Mississippi Lung Association recently recognized several Mississippi pulmonary specialists for dedication to the cause of the Christmas Seal voluntary health organization. Among those honored were: Dr. Joe R. Norman (center standing) for ten years of service as Christmas Seal Professor of Respiratory Disease, University Medical Center; four participants in the 1981 MLA Pulmonary Fellowship Program, Drs. Edward A. Holmes and Ralph R. Carter (standing) and Drs. David Westbrook and David Chase (seated); and Dr. James E. Griffith (seated at right), Chief, Pulmonary Section, VA Hospital and former MLA pulmonary fellow. The MLA medical fellowship/professorship program and special Mississippi pulmonary research projects are being continued and expanded through concern of MLA contributors and volunteers.

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CompHealth — Locum Tenens — Physicians covering physicians, nationwide, all specialties. We provide cost effective quality care. Call us day or night. T. C. Kolff, MD, President, CompHealth, 175 W. 200 S., Salt Lake City, Utah 84101, (801) 532-1200.

200 Milliamps office x-ray unit, complete with table, stand and new tube, and tank developing system, pig-o-stat, x-ray file storage, mobile screen, chest plate rack, apron and accessories. $8,000. Available now. Contact Dr. Lyle, Starkville Children's Clinic, P.O. Box 1507, Starkville, MS 39759; (601) 323-7510.

Clay Adams Electronic cell counter. Performs HGB, RBC, WBC; List $6,950.00 — sacrifice $3,500.00. Contact Robert T. Cates, M.D., (601) 856-6000.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 114th Annual Session, May 2-6, 1982, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 30-July 3, 1982, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Howard Memorial Hospital
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

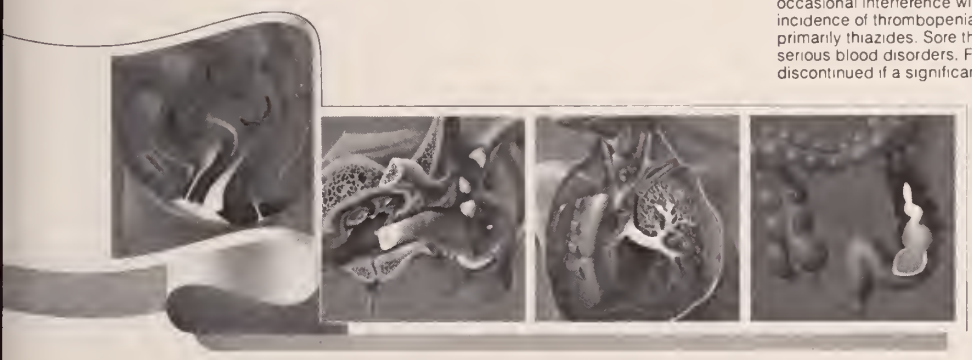
Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy



in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistent *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Division of Hoffmann-La Roche Inc.
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Bactrim™ succeeds

in recurrent urinary tract infection



from site to source

Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN. *N Engl J Med 303* 426-432, Aug 21, 1980 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

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*due to susceptible strains of indicated organisms

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October 1981

JOURNAL of the MISSISSIPPI State Medical Association

This Month:

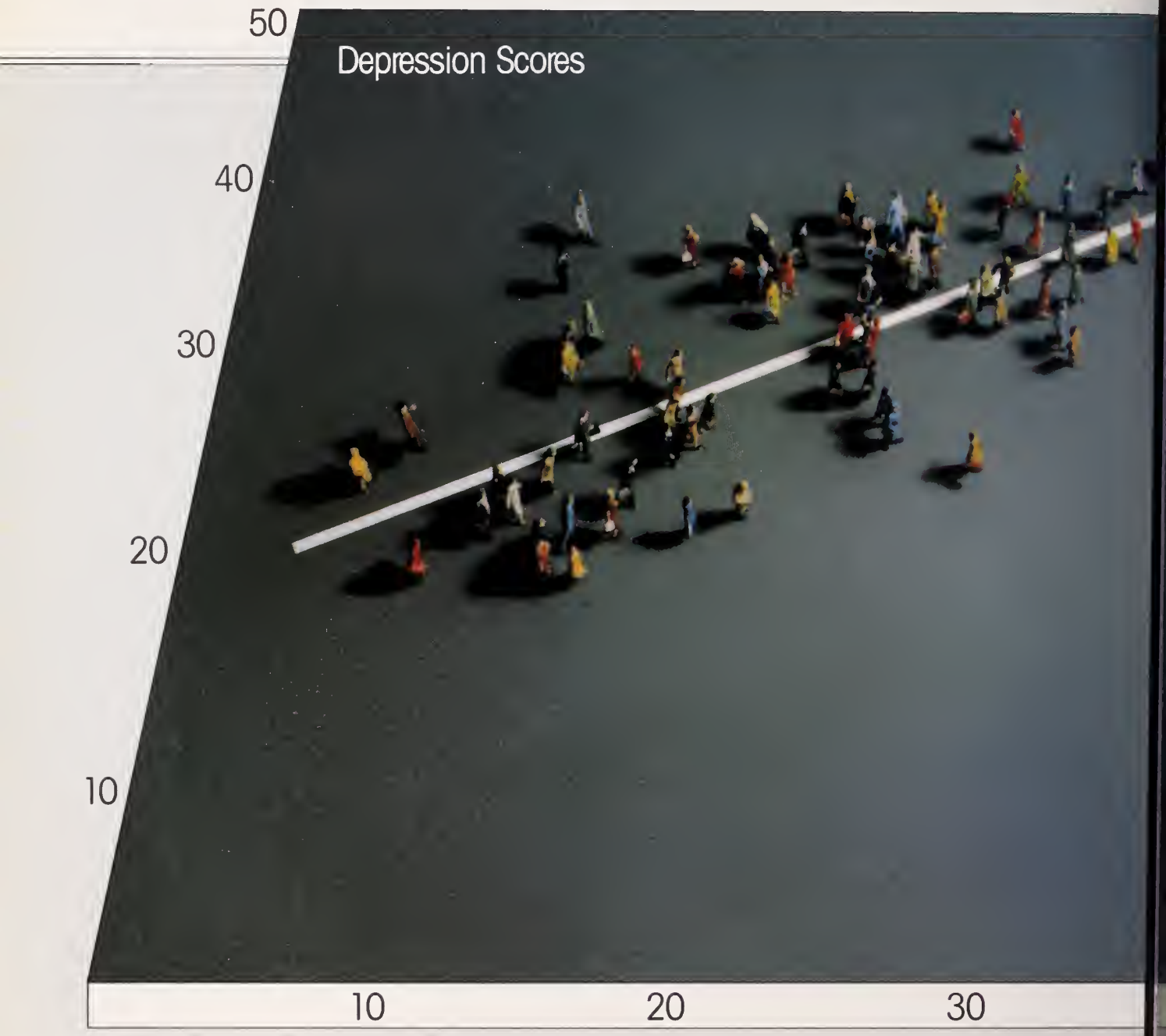
Pulmonary Arteriovenous Fistula: A Case Report

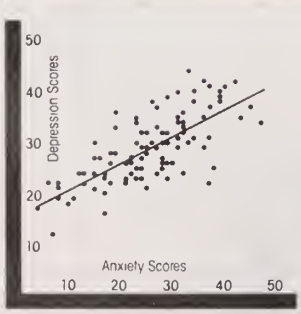
The Genogram: A Structured Approach to the Family History

Computed Tomography Diagnosis Of Acoustic Neuroma

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FOR THE 7 OF 10 NONPSYCHOTIC





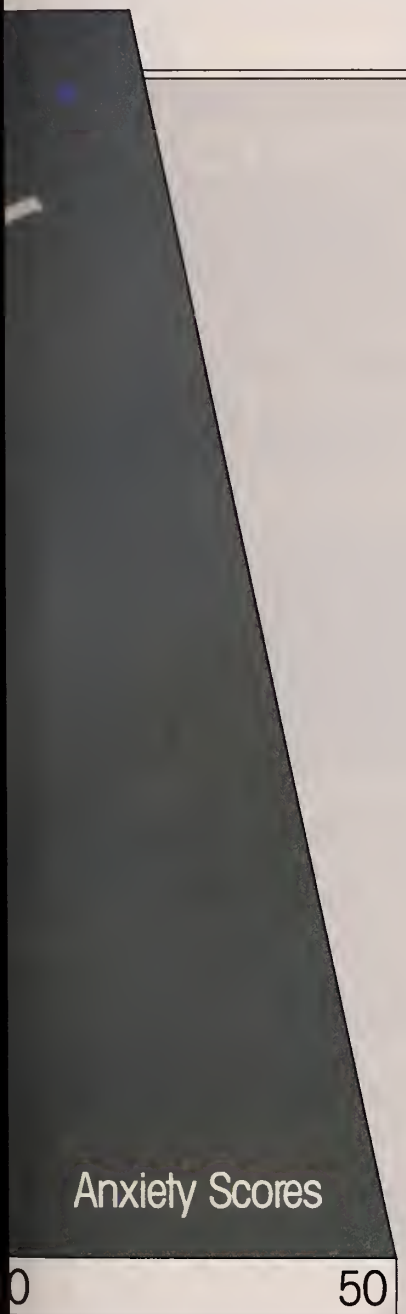
Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]



Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

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References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Clagharn J: The anxiety-depression syndrome. *Psychosamatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

In moderate depression and anxiety

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Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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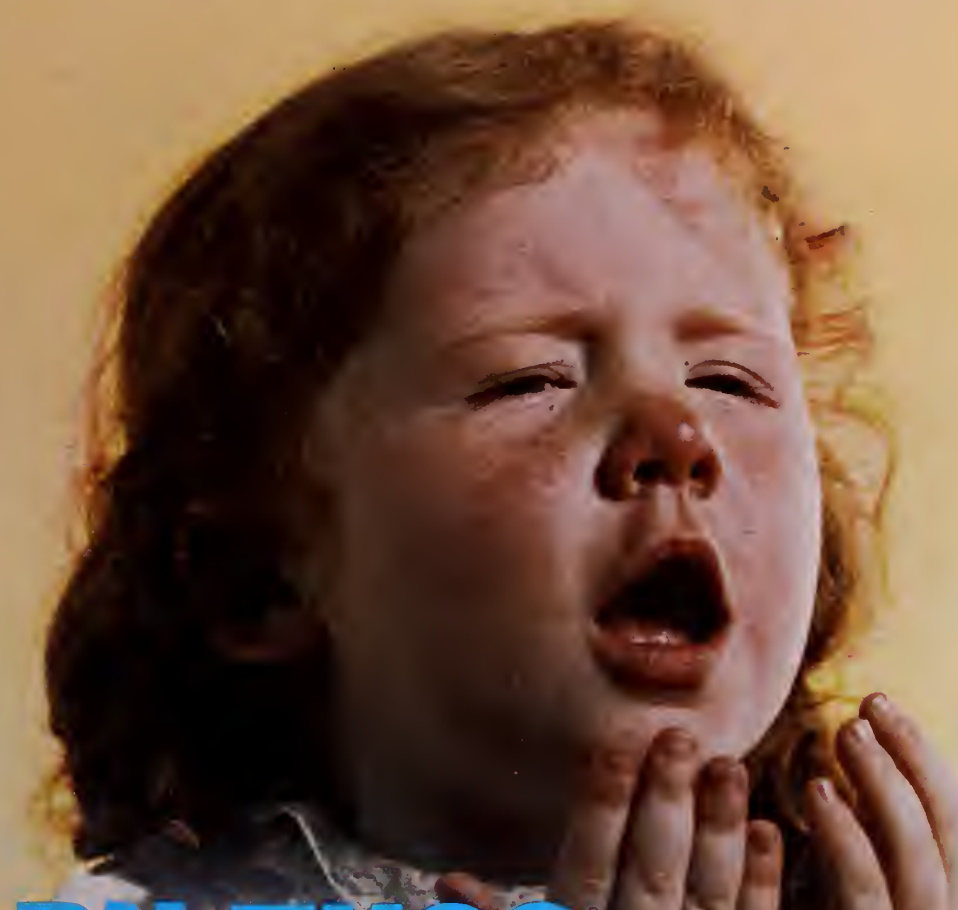
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Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings.)

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

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CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease. Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

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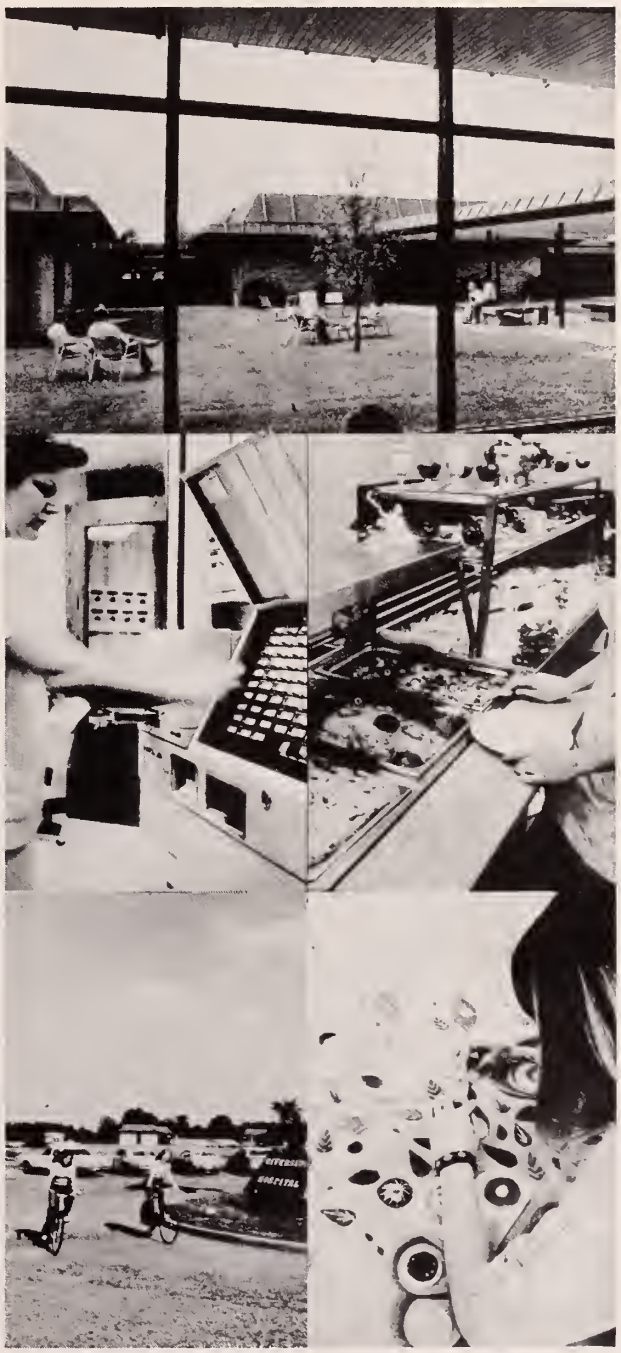
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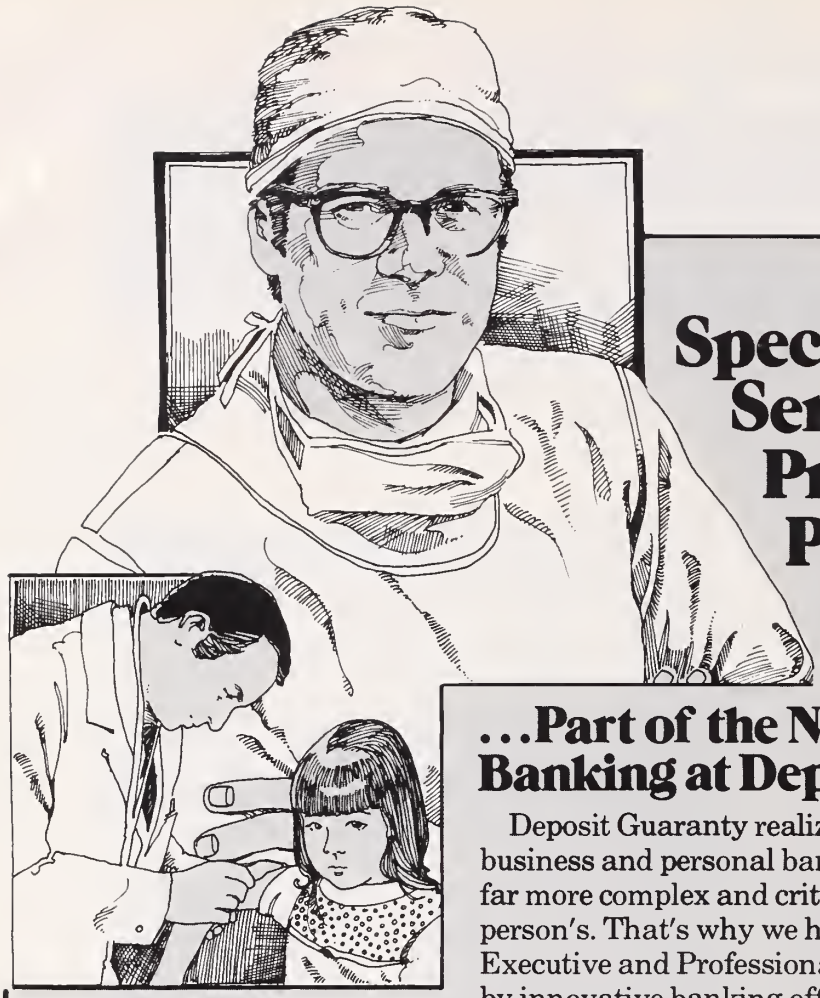
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NEWSLETTER

October 1981

Dear Doctor:

The massive wave of teenage pregnancies and spreading venereal disease should be combatted by widely advertising contraceptives on television and in the public press, says an adolescent medicine specialist in the August issue of American Journal of Diseases of Children. Donald E. Greydanus, M.D., of the University of Rochester Medical Center says many young people are not aware of specific means to prevent or reduce the risk of pregnancy or disease.

> In advocating increased education through those powerful media, he estimated a reduction in teenage pregnancy by more than 300,000 annually. "This is not to condone or encourage adolescent sex, but to acknowledge its existence and take a responsible step for the solution of attendant problems," he stated.

Educating the public about medical quackery is the purpose of a new brochure issued by the Federal Postal Inspection Service. "Do You Believe in Magic?" urges patients to discuss medical problems with their family physician and warns of sophisticated salespeople who use deceptive advertising to offer "miracles." The brochure also urges people to report suspected medical fraud.

New York Telephone Company credits nine health promotion programs with saving $2.7 million in reduced absenteeism and treatment costs for employees last year, of which $1.5 million was related to alcohol related disabilities. In addition to the alcohol rehabilitation program, the company also offered programs on fitness training, stress management, hypertension, and others.

Stress management is the topic of the MSMA Auxiliary's Fall Workshop, set for Oct. 20-21 at the Downtowner in Jackson. Speakers will be Dr. Bill Shafer and Ms. Joanne Stevens, psychology department faculty members at the University of Southern Mississippi. Rev. David Redding, author of 15 books, and Dr. Tom Elkin, head of the Memphis Christian Psychological Center, will speak on Wednesday.

Elsewhere in this issue is a report on plans for the 114th Annual Session, May 2-6, 1981, in Biloxi. Special events have been planned to celebrate the 125th anniversary of MSMA, including an exhibit of medical artifacts and a party honoring past presidents. More details will be outlined in upcoming issues of Journal MSMA. Members are urged to make plans now to attend.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

New from Janssen Pharmaceutica: Introducing a promising new approach to histoplasmosis therapy

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Effective:

"...ketoconazole may prove to be the drug of choice for...histoplasmosis."[1]

Clinical trials employing 200-400 mg NIZORAL per day have shown a combined response rate* of 84% after 10 (median) weeks of therapy.[2] In a recent study in normal (not immunocompromised) hosts, 6 out of 7 patients with progressive cavitary histoplasmosis achieved clinical and radiographic cures after 100 days on 200 mg ketoconazole per day.[2] (Recommended minimum treatment is 180 days.)

Safe:

"...can be safely administered for prolonged periods..."[3]

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Convenient:

once-a-day oral regimen fosters compliance...facilitates use both in and out of the hospital.



Top: Histoplasmosis in 56 kg man.

Bottom: After 90 days oral NIZORAL therapy.

*Includes cases in remission or markedly improved (no evidence of active disease); both mycological and clinical criteria were considered in measuring overall response.

For further information on NIZORAL write: Professional Services, Janssen Pharmaceutica Inc., 501 George St., New Brunswick, N.J. 08903.

See the facing page for Complete Prescribing Information.

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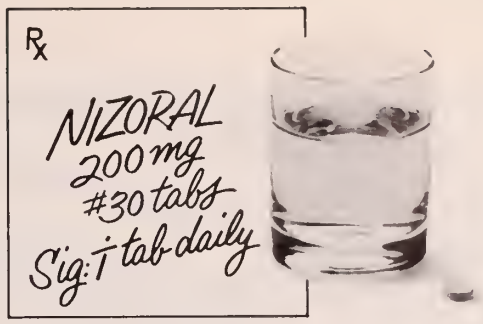
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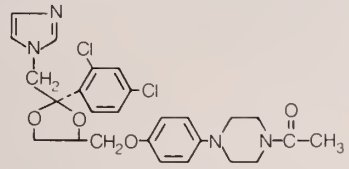
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(ketoconazole)

One tablet a day provides broad-spectrum antimycotic efficacy



DESCRIPTION

NIZORAL™ (ketoconazole) is a synthetic broad-spectrum antifungal agent available in scored white tablets, each containing 200 mg ketoconazole. Ketoconazole is *cis*-1-acetyl-4-[4-[[2-(2,4-dichlorophenyl)-2-(1*H*- imidazol-1-ylmethyl)-1,3-dioxolan-4-yl]methoxy]phenyl]piperazine and has the following structural formula:



NIZORAL™ is a white to slightly beige, odorless powder, soluble in acids, with a molecular weight of 531.44.

CLINICAL PHARMACOLOGY

Mean peak plasma levels of approximately 3.5 μg/ml are reached within 1 to 2 hours, following oral administration of a single 200 mg dose taken with a meal. Subsequent plasma elimination is biphasic with a half-life of 2 hours during the first 10 hours and 8 hours thereafter. Following absorption from the gastrointestinal tract, NIZORAL™ is converted into several inactive metabolites. The major identified metabolic pathways are: oxidation and degradation of the imidazole and piperazine rings, oxidative O-dealkylation and aromatic hydroxylation. About 13% of the dose is excreted in the urine, of which 2 to 4% is unchanged drug. The major route of excretion is through the bile into the intestinal tract. *In vitro*, the plasma protein binding is about 99%, mainly to the albumin fraction. Only a negligible proportion of NIZORAL™ reaches the cerebral spinal fluid. NIZORAL™ is a weak dibasic agent and thus requires acidity for dissolution and absorption.

NIZORAL™ is active against clinical infections with *Candida* spp., *Coccidioides immitis*, *Histoplasma capsulatum*, *Paracoccidioides brasiliensis*, and *Phialophora* spp. Development of resistance to NIZORAL™ has not yet been reported.

The following preclinical data are available; however, their clinical significance is unknown. NIZORAL™ is active *in vitro* against dermatophytes, dimorphic fungi, eumycetes, yeasts, actinomycetes, phycomycetes and various other fungi. In animal models, activity has been demonstrated against *Candida* spp., dermatophytes (*Trichophyton* spp., *Microsporum* spp., *Epidermophyton floccosum*), *Blastomyces dermatitidis*, *Histoplasma capsulatum*, *Malassezia furfur*, *Coccidioides immitis*, and *Cryptococcus neoformans*.

Mode of Action: *In vitro* studies suggest that NIZORAL™ impairs the synthesis of ergosterol, which is a vital component of fungal cell membranes. Tests in animals suggest this mechanism is not important in mammalian cells.

INDICATIONS AND USAGE

NIZORAL™ is indicated for the treatment of the following fungal infections: candidiasis, chronic mucocutaneous candidiasis, oral thrush, candiduria, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis. NIZORAL™ should not be used for fungal meningitis because it penetrates poorly into the cerebral-spinal fluid.

For the initial diagnosis, the infective organism should be identified; however, therapy may be initiated prior to obtaining laboratory results.

CONTRAINDICATIONS

NIZORAL™ is contraindicated in patients who have shown hypersensitivity to the drug.

WARNINGS

In female rats treated three to six months with ketoconazole at dose levels of 80 mg/kg and higher, increased fragility of long bones, in some cases leading to fracture, was seen. The maximum "no-effect" dose level in these studies was 20 mg/kg (2.5 times the maximum recommended human dose). The mechanism responsible for this phenomenon is obscure. Limited studies in dogs failed to demonstrate such an effect on the metacarpals and ribs.

PRECAUTIONS

General: In four subjects with drug-induced achlorhydria, a marked reduction in NIZORAL™ absorption was observed. NIZORAL™ requires acidity for dissolution. If concomitant antacids, anticholinergics, and H_2-blockers are needed, they should be given at least two hours after NIZORAL™ administration. In cases of achlorhydria, the patients should be instructed to dissolve each tablet in 4 ml aqueous solution of 0.2 N HCl. For ingesting the resulting mixture, they should use a glass or plastic straw so as to avoid contact with the teeth. This administration should be followed with a cup of tap water.

Drug Interactions: There is no evidence for clinically significant interaction with oral anticoagulant or oral hypoglycemic agents.

Carcinogenesis, Mutagenesis, Impairment of Fertility: The dominant lethal mutation test in male and female mice revealed that single oral doses of NIZORAL™ as high as 80 mg/kg produced no mutation in any stage of germ cell development. The Ames' *Salmonella* microsomal activator assay was also negative.

Pregnancy: Teratogenic effects. *Pregnancy Category C.* NIZORAL™ has been shown to be teratogenic (syndactylia and oligodactylia) in the rat when given in the diet at 80 mg/kg/day, (10 times the maximum recommended human dose). However, these effects may be related to maternal toxicity, evidence of which also was seen at this and higher dose levels.

Nonteratogenic effects: NIZORAL™ has also been found to be embryotoxic in the rat when given in the diet at doses higher than 80 mg/kg during the first trimester of gestation.

In addition, dystocia (difficult labor) was noted in rats administered NIZORAL™ during the third trimester of gestation. This occurred when NIZORAL™ was administered at doses higher than 10 mg/kg (higher than 1.25 times the maximum human dose).

It is likely that both the malformations and the embryotoxicity resulting from the administration of NIZORAL™ during gestation are a reflection of the particular sensitivity of the female rat to this drug. For example, the oral LD_{50} of NIZORAL™ given by gavage to the female rat is 166 mg/kg, whereas in the male rat the oral LD_{50} is 287 mg/kg.

Nursing Mothers: Since NIZORAL™ is probably excreted in the milk, mothers who are under NIZORAL™ treatment should not breast-feed the child.

Pediatric Use: Safety in children under two years of age has been documented in a limited number of cases.

ADVERSE REACTIONS

NIZORAL™ is usually well tolerated. Most adverse reactions reported have been mild and transient and have only rarely required withdrawal of therapy.

The most frequent adverse reactions were nausea and/or vomiting, which occurred in approximately 3% of patients. Abdominal pain was reported in approximately 1.2% of patients; pruritus in approximately 1.5% of patients. The following have been reported in less than 1% of patients: headache, dizziness, somnolence, fever and chills, photophobia, and diarrhea. Infrequent, transient increases in serum liver enzymes have been seen.

OVERDOSAGE

In the event of accidental overdosage, supportive measures, including gastric lavage with sodium bicarbonate, should be employed.

DOSAGE AND ADMINISTRATION

Adults: The recommended starting dose of NIZORAL™ is a single daily administration of 200 mg (one tablet). In very serious infections or if clinical responsiveness is insufficient within the expected time, the dose of NIZORAL™ may be increased to 400 mg (two tablets) once daily.

Children:

Children weighing 20 kg or less: . . . . . 50 mg (¼ tablet) once daily
Children weighing 20-40 kg . . . . . 100 mg (½ tablet) once daily
Children weighing over 40 kg: . . . . . 200 mg (1 tablet) once daily

Generally, treatment should be continued until all clinical and laboratory tests indicate that active fungal infection has subsided. Inadequate periods of treatment may yield poor response and lead to early recurrence of clinical symptoms. Minimum treatment for candidiasis is one or two weeks. Patients with chronic mucocutaneous candidiasis usually require maintenance therapy. Minimum treatment for the other indicated systemic mycoses is six months.

HOW SUPPLIED

NIZORAL™ is available as white, scored tablets containing 200 mg of ketoconazole debossed "JANSSEN." They are supplied in bottles of 60 tablets.

U.S. Patent Pending
NDC 50458-220-06 (60 tablets)

May 1981

Manufactured by:
Janssen Pharmaceutica n.v.
B-2340 Beerse, Belgium

For:
Janssen Pharmaceutica Inc.
New Brunswick, New Jersey 08903 USA

References:

1. Negroni R, Robles AM, Arechavala A, et al: Ketoconazole in the treatment of paracoccidioidomycosis and histoplasmosis. *Reviews of Infectious Diseases* 2 (4): 643-648, 1980. **2.** Data on file, Janssen Pharmaceutica. **3.** Graybill JR, Lundberg D, Donovan W, et al: Treatment of coccidioidomycosis with ketoconazole: Clinical and laboratory studies of 18 patients. *Reviews of Infectious Diseases* 2 (4): 661-673, 1980.

Committed to research...
because so much remains to be done.

JANSSEN PHARMACEUTICA

Janssen Pharmaceutica Inc., 501 George St., New Brunswick, N.J. 08903



Think of it as a light switch. Or a thermostat.

Now your telephone system can do much more than speed up your hospital's information flow. It can cut energy costs as well. By as much as 20% a year.

The nerve center of Bell's Hospital Communications Management System, a Dimension® PBX with Energy Communications Service (ECS) can be programmed to manage and control your energy usage more effectively. To start up, shut down, or cycle all energy systems to minimize unnecessary costs. And because ECS basically uses existing telephone lines, you save considerably on the cost of installation. Right from the start.

The same system makes all your communications more efficient, less labor-intensive. And it helps streamline crucial hospital administrative functions.

Controlling energy with your telephone is as easy as flipping a switch. It begins with a Bell System Energy Study at your hospital. Start the process with a call to your Bell System Account Executive. **South Central Bell.**

The knowledge business

DATELINE

New Hypertension Target Population

Jackson, MS - The High Blood Pressure Advisory Committee of the Mississippi Affiliate of the American Heart Association has recommended that the cutoff for referral to a physician be lowered from 160/95 to 150/90. This action means that the MHA high blood pressure and referral program has a new target population. The committee's decision was based on yet-to-be published data from the Hypertension Detection and Follow-up Program sponsored by the National Heart, Lung and Blood Institute.

AMA Adds To Video Clinic Library

Chicago, IL - Two new programs, "Primary Care of Common Sexual Problems" and "Chronic Obstrictive Pulmonary Disease," have been added to the AMA Video Clinic library. A total of 17 videocassete programs are now available for rental or sale. The Video Clinics are comprehensive two to six hour study courses that analyze the physiology, etiology, diagnosis, treatment and prognosis of the topics. All are available from the AMA's Division of Marketing and Meeting Services.

Alcohol and Drug Center Opens

Jackson, MS - Elise Winter, wife of Governor William Winter, and Jackson Mayor Dale Danks were among those making remarks at the opening of the Alcohol and Drug Center at Doctor's Hospital in Jackson last month. The program, the second of its kind in the nation, is the first part of a four-phase treatment program for addiction. Dr. D. P. Smith, head of MSMA's Disabled Doctor's Program, is director of the Center, which emphasizes treatment for impaired professionals.

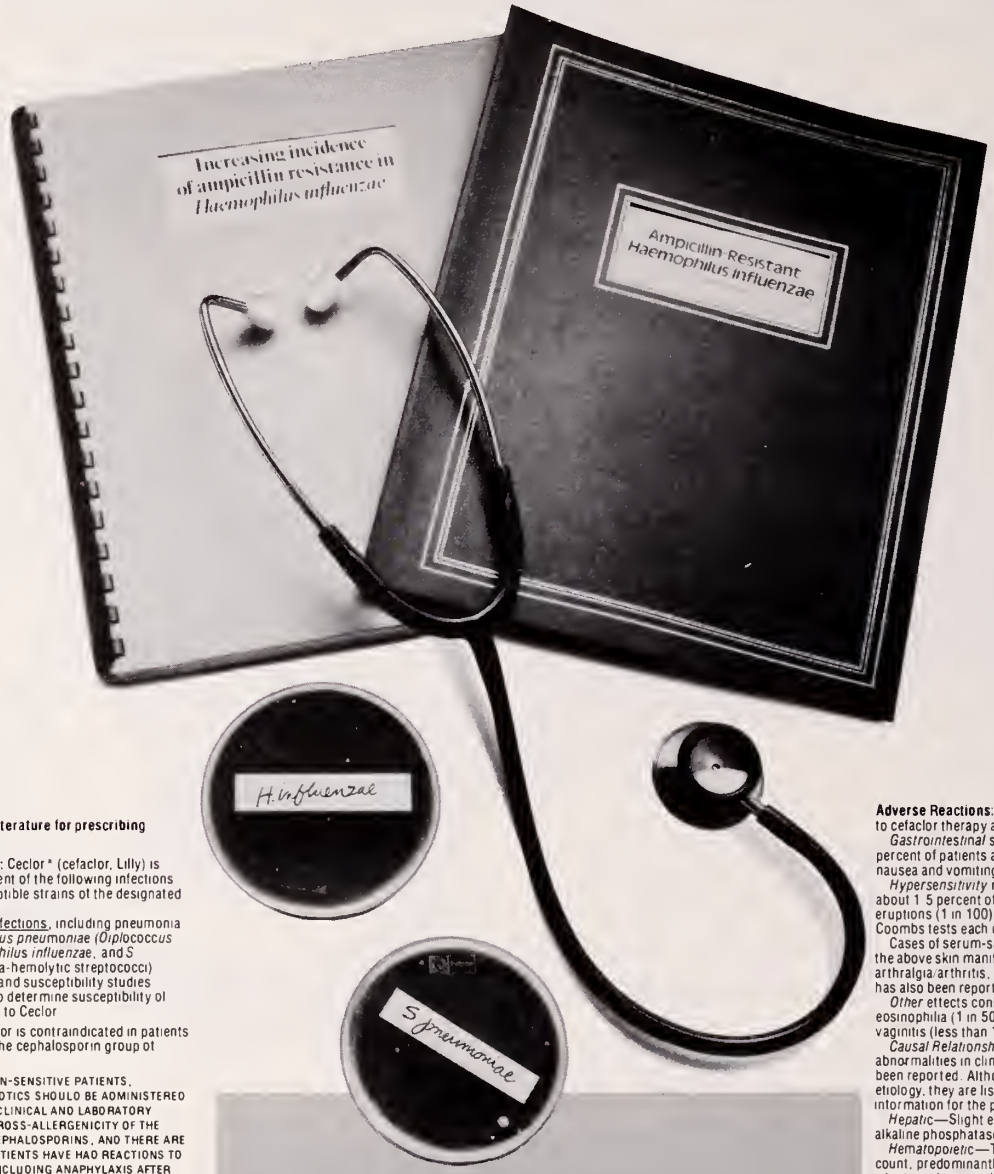
GI Disease Is Symposium Topic

Gulfport, MS - A symposium on gastrointestinal disease is scheduled for Nov. 14 at the Broadwater Beach Hotel in Biloxi. Designed for practicing internists, family physicians, pediatricians and general surgeons with a special interest in GI disorders, the course will discuss irritable bowel syndrome, hepatitis, GI bleeding, pancreatitis, cirrhosis and peptic ulcer. For more information, write CME, Gulf Coast Community Hospital, P. O. Box 4518, Biloxi, MS 39531.

Medical Exhibit At State Museum

Jackson, MS - MSMA is seeking contributions to fund a proposed "country doctor's office" in the new Mississippi Agricultural and Forestry Museum being constructed in Jackson. This project is being sponsored as one of several events to recognize the association's 125th anniversary year. The museum's prupose is to preserve the rural heritage of Mississippi, and the facility is expected to entertain and educate thousands of visitors each year.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* *

Note Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1 Antimicrob Agents Chemother , *8*:91, 1975
2 Antimicrob Agents Chemother , *11*:470, 1977
3 Antimicrob Agents Chemother , *13*:584, 1978
4 Antimicrob Agents Chemother , *12*:490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II:880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother , *13*:861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr., and J E Bennett), p. 487. New York John Wiley & Sons, 1979

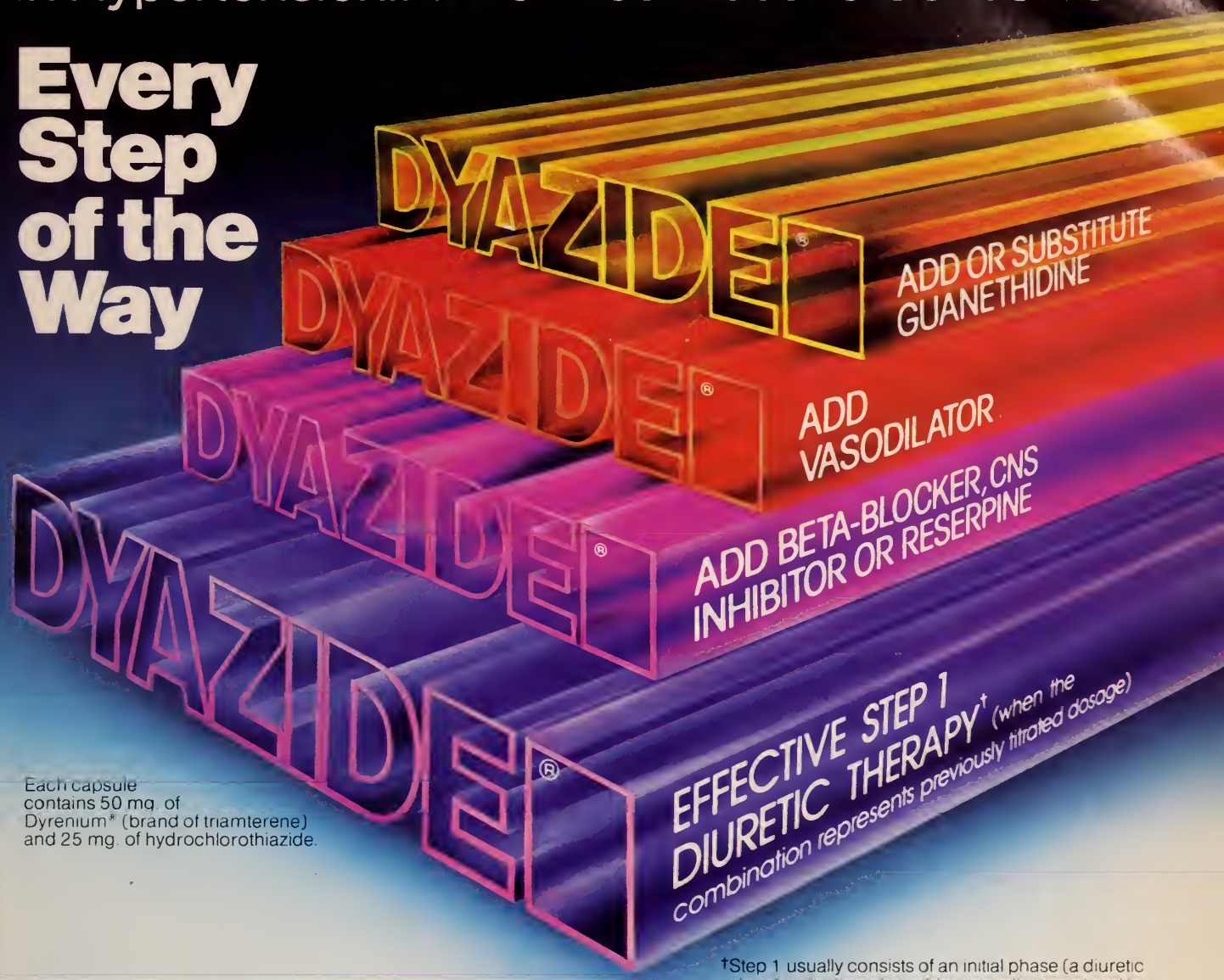
Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina Puerto Rico 00630

100061

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium* (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and Dyazide should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide' although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

SK&F CO.
a SmithKline company
Carolina, P.R. 00630



No one wakes up thinking, "Today I'm going to abuse my child."

Abuse is not something we think about. It's something we do.

Last year in America, an estimated one million children suffered from abuse and neglect, and at least 2,000 of them died needless, painful deaths.

The fact is, child abuse is a major epidemic in this country.

The solution? Part of it lies in your hands. With enough volunteers, local child abuse prevention programs could be formed to aid parents and children in their own communities. With your help, most abusers could be helped. Please write for more information on child abuse and what you can do.

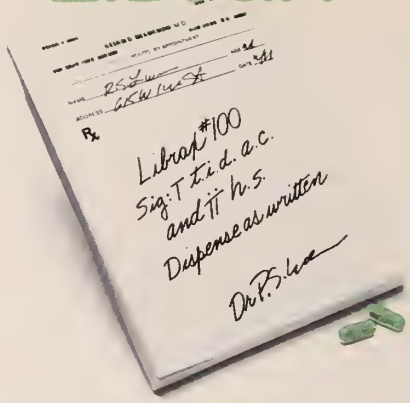
What will you do today that's more important?

Abused children are helpless. Unless you help.

Write: National Committee for Prevention of Child Abuse, Box 2866, Chicago, Ill. 60690

A Public Service of This Magazine & The Advertising Council

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

ROCHE®

Roche Products Inc.
Manati, Puerto Rico 00701

Irritable BOWEL SYNDROME*

Artist's concept of myoelectrical slow waves of the colon which seem to determine the frequency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

Librax: A logical choice for patients with IBS

Logical, because the antimotility-antispasmodic actions of the Quarzan®(clidinium bromide/Roche) component of Librax can help to relieve the distressing abdominal symptoms associated with IBS.* Logical, because the antianxiety actions of the Librium® (chlordiazepoxide HCl/Roche) component can help to reduce the excessive anxiety that can contribute to IBS flare-ups.

References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med* 298:878-883, Apr 20, 1978.
2. Snape WJ *et al: Gastroenterology* 72: 383-387, Mar 1977.

Specify Adjunctive **Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

ROCHE®

*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.



Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate* Dospan* ℞

(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation." [2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense. And it's responsible medicine.

Merrell Dow

*Registered Trademarks of MERRELL-NATIONAL LABORATORIES Inc., Cayey, Puerto Rico 00633

References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York. Raven Press, 1978, pp. 391-404.

Tenuate* ℞
(diethylpropion hydrochloride USP)

Tenuate Dospan* ℞
(diethylpropion hydrochloride USP) controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine*) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage

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EQUAGESIC— Abbreviated Summary

*__INDICATIONS__: Based on a review of this drug by the National Academy of Sciences—National Research Council and other information, FDA has classified the indications as follows:
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION. An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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for mild to moderate pain

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WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g., driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 600 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**)
Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as local or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g., caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors, and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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ORIGINAL PAPERS

Pulmonary Arteriovenous Fistula: A Case Report

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Jackson, Mississippi

ANOMALOUS CONNECTIONS BETWEEN the pulmonary artery and pulmonary vein have been variously termed pulmonary arteriovenous (PAV) aneurysms, PAV malformations, PAV varices, PAV angiomatosis and cavernous hemangiomas of the lung. These lesions represent, both anatomically and physiologically, PAV fistulae (PAVF) and should be referred to as such.

The first published description of PAVF is credited to T. Churton, a London pathologist, in 1897. He found multiple "pulmonary artery aneurysms" at autopsy in a patient known to have a systolic thoracic bruit in life.[1]

Smith and Horton of the Mayo Clinic provided the initial report of an antimortum diagnosis of PAVF.[2] In 1939, they presented a 40-year-old male with clubbing, cyanosis, dyspnea and polycythemia. A "continuous blowing" bruit was present over the right lower lobe where a chest x-ray, following peripheral venous injection of contrast material, demonstrated dilated vessels arising in the right hilum and communicating with the parenchyma of the lung. The diagnosis of PAVF was based on these findings and the patient was treated with "venesection at frequent intervals" with unreported final result.

The clinical diagnosis of PAVF was again reported in 1942 by Hepburn and Dauphinee in a clubbed, cyanotic, dyspneic and polycythemic 23-year-old.[3] Following an inadequate response to artificial pneumothorax, Shenstone and Jones performed a pneumonectomy on this patient, achieving complete resolution of her symptoms.[4] This case represented the first successful surgical management of PAVF.

From the Department of Surgery University of Mississippi Medical Center, Jackson, MS

Etiology

Pulmonary arteriovenous fistulae are usually congenital but can be acquired. Congenital PAVF are the result of abnormal development of the pulmonary capillaries and are associated with Rendu-Osler-Weber syndrome in 50%-60% of cases.[5] These patients, in addition to the pulmonary lesions, have multiple arteriovenous fistulae on the skin and mucous membranes. Epistaxis is also a commonly associated finding.

Acquired PAVF are rare, and most often are the result of chest trauma, either blunt or penetrating, but may occur secondary to chronic hepatic cirrhosis, pulmonary schistosomiasis and carcinomas.[6-8]

Pathology

Arteriovenous connections of the pulmonary circulation are frequently multiple and most often located in the lower lobe.[5] These lesions appear grossly as thin-walled saccular dilatations lined with endothelium which lie just beneath the visceral pleural surface. The afferent pulmonary arteries as well as the draining pulmonary veins are dilated and irregular secondary to increased blood flow.

Microscopic examination demonstrates tortuous

arteriovenous channels with areas of thickened endothelium and variable amounts of connective tissue and fibrosis.

Pathophysiology

The presence of an AV fistula in the pulmonary circulation represents a right to left shunt with attendant arterial oxygen desaturation. The resulting chronic hypoxia stimulates erythropoiesis producing secondary polycythemia. The increased cellular volume of the blood is not accompanied by increased plasma volume, therefore cardiomegaly and circulatory overload are not present as in systemic AV fistulae.

Hemodynamic measurements in patients with pulmonary arteriovenous fistulae have revealed normal pulmonary artery pressures and normal pulmonary vascular resistance even when shunts of 50% or more of the cardiac output are present.[9-11]



Figure 1. Selective pulmonary arteriogram demonstrating two large PAVF.



Figure 2. Operative exposure of subserosal, thin-walled PAVF.

Complications

The presence of a large right to left intrapulmonary shunt places these patients at risk for significant complications. Emboli, both paradoxical and arising within the fistula itself, may result in cerebrovascular accidents. These emboli may be septic with brain abscess formation as the ultimate result. Neurologic complications may also result from sludging in the cerebral microcirculation due to polycythemia. Rupture of fistulae into the pleural space or into a bronchus is also a recognized complication, often with fatal outcome.

Hemoptysis and epistaxis are frequently described as complications of PAVF but more probably represent either unappreciated *forme fruste* or undiagnosed Rendu-Osler-Weber syndrome. A positive family history may be present in as many as 15% of cases.

Case Report

This 44-year-old college instructor was in good general health except for fatigue with moderate exercise. On May 10, 1980, he suffered a cerebrovascular accident manifested as right hemiparesis and expressive aphasia. During his subsequent hospitalization, he was found to have a markedly low P_aO_2 and an unexplained density in the left hemithorax on chest x-ray. He was presumptively diagnosed as having a pulmonary embolus, and Heparin was begun.

He was referred for further evaluation and treatment and again a low P_aO_2 and a persistent radiodensity was noted on chest x-ray. Examination at this time also demonstrated mild cyanosis of the mucous membranes and nail beds as well as digital clubbing. A pulmonary arteriogram revealed two large PAVF in the left lung (see Figure 1).

Hemodynamics obtained during arteriography were normal with a right atrial pressure of 4 mm Hg, right ventricle 16/4 mm Hg, pulmonary artery 14/2 mm Hg, pulmonary artery mean 7 mm Hg, and a pulmonary capillary wedge pressure of 5 mm Hg. Pulmonary artery saturation by oxymeter was 60.0%.

A left thoracotomy was performed on June 20, 1980, and two large subpleural vascular masses were found, one in the lingula, and one in the left lower lobe (see Figure 2). These lesions were wedge resected in a nonanatomic fashion using a GIA stapling device. A minimum of lung tissue was sacri-



Figure 3. Dissection of lingular PAVF demonstrating thin wall, smooth endothelial lining and cavernous arteriovenous communication.

ficed with this method. Arterial blood gases obtained intraoperatively on mechanical ventilation and an F_IO_2 of 0.50 were 81/37/7.38. Following resection of one fistula, these values were 163/33/7.41 and ultimately became 245/29/7.40 following resection of the second fistula. All blood gas values were obtained on identical ventilation settings.

This patient's post-operative course was uncomplicated, and he was able to return to rehabilitation from his neurologic deficits with a markedly increased exercise tolerance and resolution of his cyanosis.

Discussion

The presentation, complications and management of PAVF are illustrated in the above case. The classic clinical findings of dyspnea, cyanosis, clubbing and an abnormal chest x-ray are also demonstrated, as well as cerebrovascular accident as a complication of PAVF.

Previous studies of intra-pulmonary shunts have revealed essentially normal hemodynamics with the exception of the shunt itself. This also is illustrated in this case.

The presence of a lung lesion associated with clubbing, cyanosis or polycythemia should suggest the diagnosis of PAVF. A careful examination for telangiectasia and a careful history for epistaxis, as well as arterial blood gases, should be part of the initial examination. The diagnosis is confirmed by pulmonary arteriography.

Management of this lesion is surgical except in the case of multiple bilateral fistulas which make resection impractical. When resection is performed, it should be as conservative as possible with the sacrifice of a minimal amount of lung tissue.

References

1. Churton, T.: Multiple aneurysms of the pulmonary artery. Br. Med. J. 1223(1):1897.
2. Smith, H. L. and Horton, B. T.: Arteriovenous fistula of the lung associated with polycythemia vera: Report of a case in which the diagnosis was made clinically. Am. Heart J. 18:581-592, 1939.
3. Hepburn, J. and Dauphinee, J. A.: Successful removal of hemangioma of the lung followed by the disappearance of polycythemia. Am. J. Med. Sci. 204:681-685, 1942.
4. Shenstone, N. S.: Report of a case of cavernous angioma of the lung. Brunn Tributes 503-507, 1942.
5. Dines, D. E., Arms, R. A., Bernatz, P. E. and Gromes, M. R.: Pulmonary arteriovenous fistulas. Mayo Clin. Proc. 49:460-465, 1974.
6. Symbas, P. N., Goldman, M., Erbesfeld, M. H. and Vlasis, S. E.: Pulmonary arteriovenous fistula, pulmonary artery aneurysm and other vascular changes of the lung from penetrating trauma. Ann. Surg. 191(3):336-340, 1980.
7. Karlish, A. J., Marshall, R., Reid, L. and Sherlock, H.: Cyanosis with hepatic cirrhosis: A case with pulmonary arteriovenous shunting. Thorax 22:555, 1967.
8. Pierce, J. A., Regan, P. and Kinball, R. W.: Unusual case of pulmonary arteriovenous fistula with a node of thyroid carcinoma as a cause. N.E.J.M. 269:901, 1959.
9. Hultgren, H. N. and Gerbode, F.: Physiologic studies in a patient with a pulmonary arteriovenous fistula. Am. J. Med. 17:126-133, 1954.
10. Gray, F. D., Lurie, P. R., and Whittemore, R.: Circulatory changes in pulmonary arteriovenous fistula. Yale J. Biol. & Med. 25:107-114, 1952.

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The Genogram: A Structured Approach to the Family History

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THE FAMILY PHYSICIAN SEES many, if not all, members of a household. These family members, as well as many of those outside of the household, may have a direct bearing on the management of the patient. Family interactions, because of numbers alone, can be complex. The genogram, which is a structured outline of the family history, is an approach to simplification of the recording of these interactions. It contains genetic, medical and psychosocial information about the family.

Cormack in 1975[1] and Hartman in 1978[2] advocated the use of a structured approach to the family history. Jolly, *et al.*, in 1980[3] studied the genogram as a reasonable method for recording a family history. Family practice residents were given brief but specific instructions on the method of recording a genogram. The average time required in this study was found to be 16 minutes. They concluded that, time-wise, the genogram is an acceptable approach to the family history.

The Department of Family Medicine at the University of Mississippi School of Medicine is currently using the genogram as a method for improving family history taking skills of senior medical students.

The purpose of this article is to present the procedure for recording a family history using the genogram. For the most part, symbols used in constructing a family genogram are the same as for constructing a family tree. Genogram symbols are given in Figure 1.

A Sample Genogram

The following family history of a patient, Eloise, is arranged in genogram format in Figure 2. By following the genogram along with the text, the procedure for constructing the genogram will become apparent.

The patient and her household. Eloise is a 41-year-old white female who was born in 1940. Her

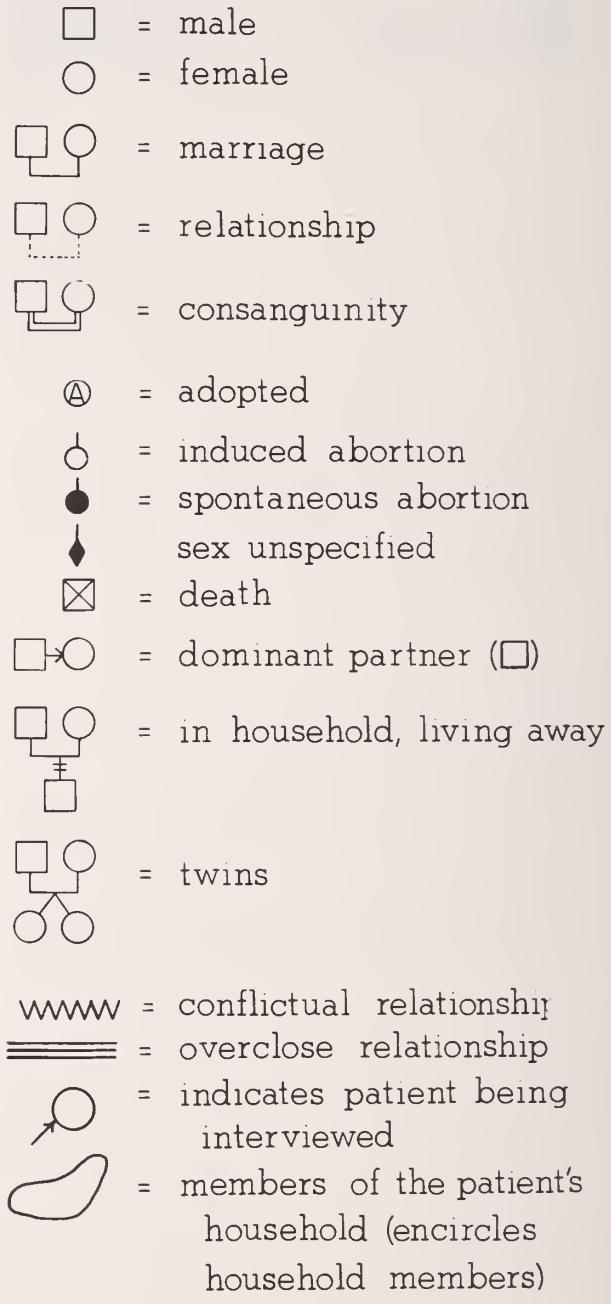


Figure 1. Genogram symbols.

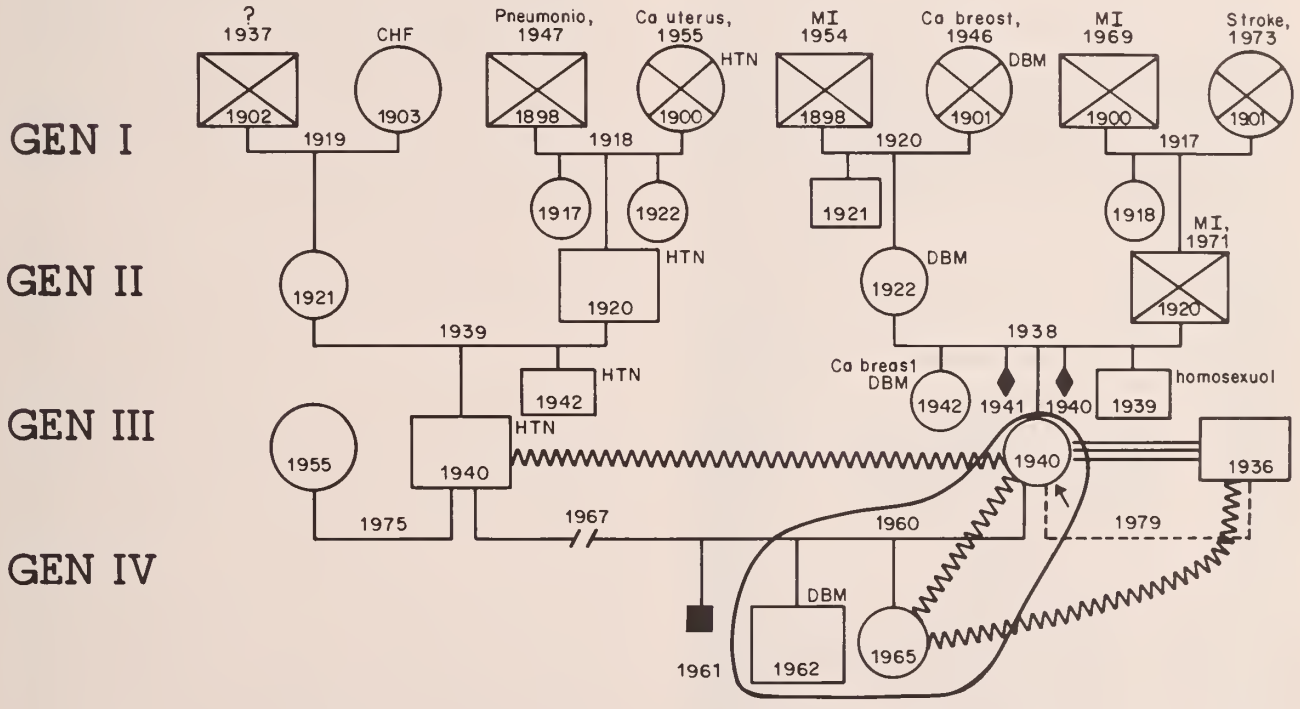
From the Department of Family Medicine, University Medical Center, Jackson, MS.

immediate household consists of herself and a son and daughter born in 1962 and 1965, respectively. Her son has diabetes mellitus. She had a spontaneous abortion of a male fetus in 1961. She attended college for two years prior to getting married in 1960. She was divorced in 1967 following an affair by her husband with his secretary. She has not yet forgiven him for this and continues to have hostile feelings towards him. Her ex-husband (born in 1940) remarried a younger woman (born in 1955) in 1975. Eloise has does not get along with her daughter, who blames her for the divorce. Eloise has been going with a business executive since 1979. She is extremely dependent on him emotionally. Eloise's daughter does not get along with this gentleman because she feels that he is trying to take her father's place.

Critical events in Eloise's life include (1) divorce in 1967, (2) attempted suicide after her divorce (1967), (3) an affair with a married man in 1969 which ended with his returning to his wife and (4) her father's death in 1971.

Dynamic changes (changes for the better) include (1) psychotherapy in 1967, (2) return to college in 1968, (3) graduation in 1970, and (4) her first job in 1970.

The patient's family. Eloise's maternal grandparents are both deceased. Her grandfather, who was born in 1898, died of a myocardial infarction in 1954. Her grandmother, who was born in 1901, died from cancer of the breast in 1946. She also had diabetes mellitus. Her maternal grandparents were married in 1920. Eloise's paternal grandparents are also both deceased. Her grandfather, who was born in 1900, died of a myocardial infarction in 1969. Her grandmother, born in 1901, died of a stroke in 1973.



DYNAMIC CHANGES

1. Psychotherapy, 1967
2. Return to college, 1968
3. Graduation, 1970
4. First job, 1970

CRITICAL EVENTS

1. Divorce, 1967
2. Attempted suicide, 1967
3. Affair with married man, 1969
4. Father's death, 1971

Figure 2. Eloise's genogram. GEN I, II, III and IV refer to family generations.

They were married in 1917. Eloise's mother was born in 1922 and has diabetes mellitus. Her mother has one brother, born in 1921, who is in good health. Eloise's father, who was born in 1920, died of a myocardial infarction in 1971. He has one sister, born in 1918, in good health. Her mother and father were married in 1938. Eloise has a sister, born in 1942, who has diabetes mellitus and has had a radical mastectomy for breast cancer. Her brother, born in 1939, is a homosexual. Her mother had spontaneous abortions in 1940 and 1941, sex unspecified.

The ex-husband's family. Eloise's ex-husband's maternal grandfather, born in 1902, died of an unknown cause in 1937. His maternal grandmother, born in 1903, is still alive and suffers from congestive heart failure. They were married in 1919. His paternal grandparents are both deceased. His grandfather, born in 1898, died of pneumonia in 1947, and his grandmother, born in 1900, died of cancer of the uterus in 1955. She also had hypertension. They were married in 1918. Eloise's ex-husband's mother, born in 1921, and father, born in 1920, were married in 1939. His father has two siblings (both girls) born in 1917 and 1922. Her ex-husband has one brother, born in 1942. The ex-husband, his brother, and his father all suffer from hypertension.

Summary

The genogram, as a structured approach to the family history, has been gaining popularity over the past few years. A number of family medicine residency programs have officially adopted it as their method of recording the family histories of all clinic patients. Although the Department of Family Medicine at the University of Mississippi School of Medicine has not gone this far, it does find the approach useful, especially when interviewing a patient whose problem has a large component of family interaction. In addition, we have found it to be a very useful method for teaching senior medical students to take and record better family histories.

References

1. Cormack, J. J.: Family Portraits: A method of recording family history. J. R. Coll. Gen. Pract. 25:520-526, 1975.
2. Hartman, A.: Diagrammatic assessment of family relationships. Soc. Casework 59:465-476, 1978.
3. Jolly, W., Froom, J. and Rosen, M. G.: The genogram. J. Fam. Prac. 10:251-255, 1980.

Radiologic Seminar CCXVII: Computed Tomography Diagnosis of Acoustic Neuroma

JAMES V. FERGUSON, JR., M.D., and MICHAEL H. CARTER, JR., M.D.
Greenwood, Mississippi

VERTIGO AND HEARING LOSS are not uncommon complaints. It is prudent to maintain a high index of suspicion in any patient with a unilateral neurosensory-type hearing loss, for this frequently is the first, and may be the only, symptom or sign of an acoustic neuroma.

Plain films and/or tomography are fairly accurate screening procedures for this type of tumor. If positive, bony erosion or at least a difference in the vertical diameter of the internal canal is detected. The vertical diameter of the internal auditory canal ranges from 2.0 mm to 9.0 mm. Discrepancies of 1.0 mm to 2.0 mm are suspicious and differences of greater than 2.0 mm are definitely abnormal. There is very little correlation between the size of the lesion and the degree of bony erosion. Small intracanalicular lesions may produce considerable erosion while large extracanalicular lesions may produce minimal erosion.

If plain film examination or routine tomography is positive, or if acoustic neuroma is strongly suspected because of clinical or audiometric findings, then computed tomography is the diagnostic procedure of choice.

Computed tomography detection of acoustic neuroma can approach 100% if the scanner has a spatial resolution of under 1.0 mm and can collimate the x-ray beam to 2.0 mm or less. Both unenhanced and enhanced scans should be obtained and the enhanced scan should have a high intravascular level of iodinated contrast medium.

The value of CT lies in the fact that both the tumor and the bony erosion can be visualized. Also, extrinsic pressure on the brainstem or hydrocephalus may be appreciated.

Sponsored by the Mississippi Radiological Society.
From the Departments of Radiology and Surgery, Greenwood Leflore Hospital, Greenwood, MS.

Case Report

This 47-year-old woman presented to the clinic in November 1980, complaining of a four year history of intermittent subjective hearing loss in the left ear and a two week history of intermittent dizziness and unsteadiness. Occasionally she had experienced a sharp discomfort in the left ear. There had been no accompanying nausea or vomiting, and she denied a



Figure 1. The unenhanced CT scan demonstrates widening of the left internal auditory canal and erosion of the temporal bone.

history of tinnitus. Another symptom which she mentioned was a sensation of burning all the way across her upper lip. This had been a pesky, persistent problem for her, and she had consulted a number of other doctors, some of whom had suggested that the burning sensation was symptomatic of an allergy.

For a few months, she had complained of subjective visual impairment, but repeated ophthalmologic examinations demonstrated good to excellent visual acuity. Pseudopapilledema had been noted in May 1980, and this finding was unchanged in August 1980.

The patient was an alert, cooperative 47-year-old woman who did not appear to be ill. The eardrums were normal, and the remainder of the head and neck examination was normal. Cranial neurologic examination was normal except for the left eighth nerve. Gait was normal. Caloric testing was not done.

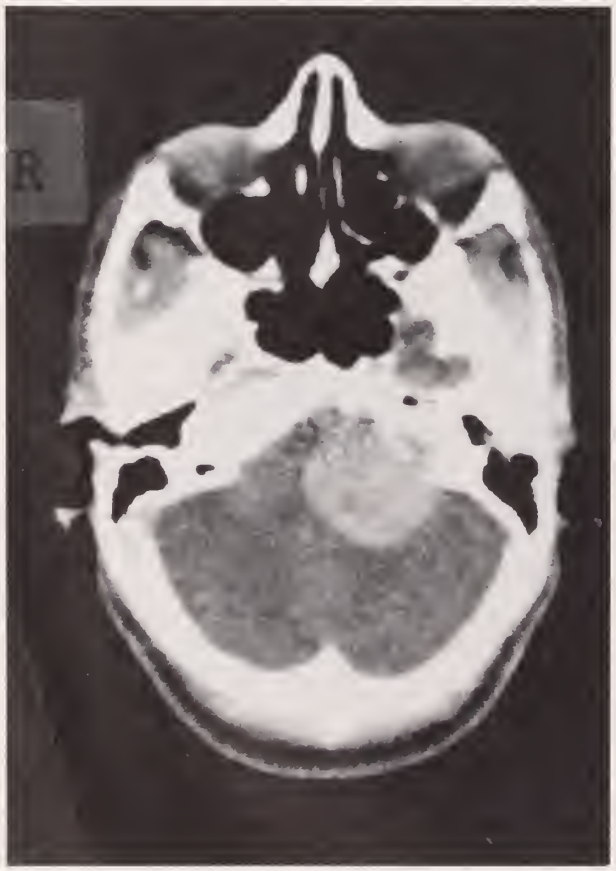


Figure 2. The post contrast scan demonstrates a 4 cm enhancing lesion in the left cerebellopontine angle with erosion of the temporal bone.

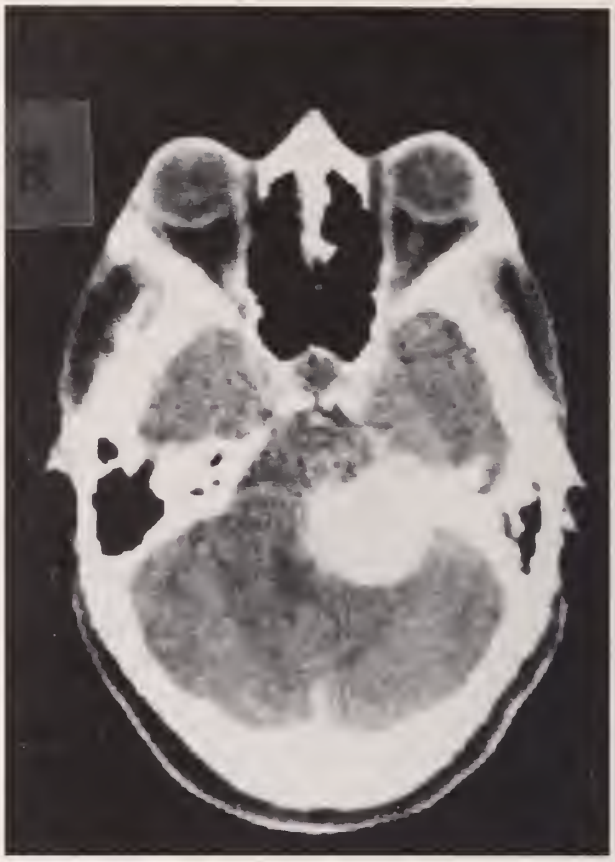


Figure 3. This post contrast scan demonstrates displacement of the fourth ventricle and the brain stem to the right by the enhancing mass.

Audiometric testing demonstrated a profound neurosensory hearing loss in the left ear with essentially normal hearing in the right ear.

Plain films were suspicious of widening of the left internal auditory canal. Cranial CT was performed. The unenhanced scan demonstrated widening of the left internal auditory canal and erosion of the temporal bone (see Figure 1). After intravenous administration of an iodide compound, the scan demonstrated a 4 cm enhancing lesion in the left cerebellopontine angle with erosion of the temporal bone (see Figure 2). Figure 3 demonstrates displacement of the fourth ventricle and the brainstem to the right.

She underwent surgical resection of the tumor by a combined translabyrinthine and suboccipital approach. An acoustic neuroma was found.

Summary

Computed tomography is an accurate and relatively noninvasive method of diagnosing acoustic

neuroma. Although expensive, CT is much cheaper than other definitive procedures and carries no more morbidity than an intravenous pyelogram. It can be performed on an outpatient basis. ★★★

1605 Strong Street (38930)

References

1. Shaffer, Katherine A. and Haughton, Victor M.: Thin section computed tomography of the temporal bone. The Laryngoscope 90:1099-1105, 1980.
2. Lincoln, Charles P. and Alson, James E.: Neuroradiologic evaluation for vertigo. Ear, Nose and Throat J. 59:354-357, 1980.
3. Valvassori, G. E. and Pierce, R. H.: The normal internal auditory canal. Am. J. Roent. 92:1232-1241, 1964.
4. Shaffer, K. A., Haughton, V. M. and Wilson, C. R.: High resolution CT of the temporal bone. Radiology 134:409-414, 1980.
5. Davis, K. R., et al: Computed tomography of acoustic neuroma. Radiology 124:81-86, 1977.

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The President Speaking

What Are You Doing?

R. FASER TRIPLETT
Jackson, Mississippi

The MSMA recently surveyed the entire membership for an opinion on its performance. Some of the results are most interesting. The survey was designed to identify where the association needs to improve its performance and where there is a lack of knowledge about the association's performance.

My initial reaction to the results was one of satisfaction in that 80% of the respondents were either satisfied or very satisfied with MSMA's overall performance or effectiveness. However, a further analysis revealed that 16% responded "neutral/I don't know" and 20% were dissatisfied with "opportunity for input from individual members." Yet when given this opportunity for input, only 19% of the members bothered to respond to the survey.

In the final analysis we must recognize that the MSMA can only be as effective and strong as its local county societies, which will only be as effective as you want them to be as individuals through your participation and effort. Do you have an active local society that meets regularly? Do you attend and give your wholehearted support? Does your society have ongoing programs to communicate with the public; to maintain contact with your legislative representatives; to keep open lines of communication with your local industries to deal with the cost and quality of medical care; to monitor and play an active role in health planning issues; and to deal with any and all other needs that so initially affect our profession today?

If you can't answer yes to all of these questions, you should stop and reflect on why not and then examine yourself to find out what you are doing to advance the cause of the profession in your community.

The MSMA can and will be only as strong and effective as you want it to be as evidenced by your active participation. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 10

OCTOBER 1981

Guest Editorial

What Is Wrong?

There was a time when the physician was highly respected in his community. He was admired for his willingness to work long hours, praised for his bedside manner, and appreciated for his dedication. While there are some physicians who still wear the halo, more and more are being depicted wearing horns. What is wrong?

In a recent survey of MSMA members, the respondents indicated that they felt the two major issues facing the profession during the coming years were cost and quality of care and the public's image of the profession.

The quality of care rendered today is better than it has ever been, but what about the cost? When was the last time you reviewed the bills you sent to your patients? Do you know how much those tests you order are costing? If you were treating yourself, would you order a risky test unless it were absolutely necessary? Certainly, the entire cost of care does not go into your pocket. But try explaining that to a middle class worker who sees you driving a Mercedes up your driveway to the biggest house in town.

After careful screening by the claims committee, recent evaluations of malpractice claims against physicians insured with the Mississippi Medical Fraternal and Educational Society indicate that only 15% of the claims have merit from a medical standpoint. Why do the patients involved in the other 85% of the claims go to a lawyer? What is wrong?

Perhaps that second issue indicated by the survey comes into play. Maybe it has something to do with the public's image of the profession. Do your patients know you work a 60 hour week? Or do they just know about Holy Wednesday? You know, Holy Wednesday. That's the day you rush through your last half dozen patients and break out the door to make a 12:30 tee time. They might even think that your "continuing education seminars" don't necessarily need to be in Hawaii, Las Vegas, or on the good ship lollipop in the Caribbean. You might have learned a lot, but do your patients know you learned a lot? Remember, it's *their* perception we are talking about.

It has been said that the practice of medicine is both an art and a science. Everyone agrees that medical science is better than it has ever been and improving daily. But what about the art of practicing medicine; the ability to communicate effectively to the patient that you too are concerned about what it all costs; the oldtime bedside manner that lets the patient know you are genuinely interested in his health? Is the art of practicing medicine improving as fast as the science? Or could it be that the loss of the art just might be what is wrong?

David R. Steckler, M.D.
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Natchez, MS 39120

Cancer Staging By the TNM System

The American Joint Committee for Cancer Staging and End-Result Reporting was organized on January 9, 1959, for the purpose of developing a system of clinical staging of cancer by site acceptable to the American medical profession. The sponsoring organizations are, the American College of Surgeons, the American College of Radiology, the College of American Pathologists, the American College of Physicians, the American Cancer Society, and the American Cancer Institute. The American College of Surgeons serves as administrative sponsor.

The TNM System provides a basis for categorizing the extent of the disease. When the TNM System is used, the letter "T" represents the primary tumor, the letter "N" represents the regional lymph node involvement, and the letter "M" represents distant metastasis. Appropriate suffixes are used to describe the absence or increasing degrees of dissemination.

(EDITORIAL/Continued)

To illustrate, a cancer of the lung less than 3 centimeters in size with metastasis to peribronchial lymph nodes but without distant metastasis would be classified as T-1, N-1, M-0. Various combinations are used to clearly describe the extent of the disease so that communication between physicians becomes precise and universally understood.

A manual for staging of cancers is available from the American Joint Committee, 55 E. Erie Street, Chicago, IL. All physicians interested in the diagnosis and treatment of cancer will find the manual an invaluable aid in the concise classification of malignancy.

GEORGE H. MARTIN, M.D.
Associate Editor

Incentives Needed For Preventive Coverage

Health insurers lack financial incentives to provide benefits for preventive care, a federally-sponsored cost-benefit analysis has shown.

The upfront cost of paying for hypertension screening or PAP smears is greater than the long-term savings the health insurer can expect to reap, the Congressional Office of Technology Assessment (OTA) concluded.

Though the costs of screening accrue only to the insurer, the benefits are widely distributed. They accrue — in the form of better health and productivity — to the people screened, their life insurers, employers, government, and society. The health insurer's benefits are reduced further because some of the people screened eventually leave the plan.

The OTA report suggested that the government could provide incentives such as tax breaks and financial assistance to establish preventive health programs in the private sector. Public-private partnership is needed, the report said, because prevention programs "are often too expensive for either the public or private sector to undertake independently."

CHARLES L. MATTHEWS
Executive Secretary

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Medico-Legal Brief

No Holds Barred In OR Assault

An orthopedist has been cleared of responsibility for a bizarre assault by a technician on a patient in the operating room.

The surgery itself — on the patient's knee — was apparently uneventful. During the operation, however, a male technician suddenly attacked the patient's genitals, inflicting injuries that were at least temporarily incapacitating.

The patient's wife sued, charging that the hospital's negligence in hiring the sexually volatile technician and the orthopedist's failure to guard against the assault had led to her loss of "consortium."

The jury in a Georgia court held that the plaintiff had indeed suffered through the negligence of the orthopedist and the hospital but estimated the damages from loss of consortium at no more than $1,000. However, the trial judge, finding the evidence insufficient to support such a verdict, overruled the decision and handed down a judgment clearing the defendants.

A Georgia Court of Appeals has now affirmed that ruling by the lower court. — Ga. App., 274 S.E.2d 72.

Council Makes Plans For 114th Annual Session

The Council on Scientific Assembly met at the MSMA headquarters office on September 10 to plan activities for the association's 114th Annual Session, set for May 2-6, 1982, at the Biloxi Hilton.

In addition to meetings of the 14 scientific sections and the House of Delegates, next year's annual session will feature special events to recognize the association's 125th anniversary year. Included in the preliminary plans are a special anniversary party honoring the past presidents of the association which will be held on Wednesday evening, and an exhibit of medical artifacts which will be on display during the five-day meeting.

The annual membership and spouse banquet is scheduled for Tuesday evening, with syndicated columnist Abigail Van Buren (Dear Abby) as guest speaker. The annual president's reception will be held Sunday evening. Medical alumni groups will host reunions on Monday night.

Tennis and golf tournaments are again on the annual session schedule, along with the popular fishing rodeo. This year, a jogging event will also be included in the special activities.

The program calls for scientific sections to meet according to the following schedule: *Sunday, May 2* — sections on orthopedic surgery, anesthesiology, pathology, psychiatry, EENT, radiology, and dermatology; *Tuesday, May 4* — sections on medicine, preventive medicine, and surgery; *Wednesday, May 5* — sections on family practice, ob-gyn, pediatrics, and urology. The annual James Grant Thompson Memorial Lecture will be presented during the meeting of the Section on Surgery.

Scientific exhibits will be on display throughout the week, with winners receiving the Aesculapius Award.

The House of Delegates will again meet on Monday and Thursday, with reference committee meetings on Monday afternoon. Also on the Monday afternoon schedule is the annual meeting of the Mississippi Foundation for Medical Care. The annual meeting of the Mississippi Medical Fraternal and Educational Society is slated for Sunday afternoon. A number of medical specialty societies are expected to schedule meetings throughout the week.

The MSMA Auxiliary will hold its 59th Annual Session concurrently with the MSMA session.

Future issues of the *Journal MSMA* will include more details about the program for the upcoming meeting. Members are urged to make plans now to attend.

Mild Hypertension Now A Target

The High Blood Pressure Advisory Committee of the Mississippi Affiliate of the American Heart Association, chaired by Richard G. Hutchinson, M.D., has recommended that the cutoff for referral to a physician be lowered from 160/95 to 150/90. This action means that Mississippi Heart Association high blood pressure and referral program has a new target population. The committee's decision was based on yet-to-be published data from the Hypertension Detection and Follow-up Program, sponsored by the National Heart, Lung and Blood Institute.

Lions Sponsor UMC Program



The Jackson Central Lions Club sponsored the third annual ophthalmology program at the University of Mississippi Medical Center. Dr. David L. Guyton (center), son of Dr. and Mrs. Arthur Guyton of Jackson, presented the seminar. Dr. Guyton is assistant professor of ophthalmology at the Johns Hopkins University School of Medicine in Baltimore. With him are (from left) Dr. Samuel Johnson, UMC professor of surgery and chief of the division of ophthalmology, and Dr. Raul Valenzuela, professor of surgery (ophthalmology). Cosponsors were the UMC Division of Ophthalmology and the Medical Center Division of Continuing Health Professional Education.

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MAFP Conducts Annual Scientific Assembly

Dr. Ben Earl Kitchens of Iuka was installed as president of the Mississippi Academy of Family Physicians at its 33rd annual Scientific Assembly. Dr. Robert L. Blake of Maysville, KY, president of the American Board of Family Practice, installed the officers and directors at the Biloxi meeting, held July 29-August 1.

New officers of the MAFP are Dr. Louis Rubenstein of Ocean Springs, president-elect; Dr. Hardy Woodbridge, Jr., of Jackson, vice president; Dr. James Waites of Laurel, secretary-treasurer; Dr. Edward Hill of Hollandale, delegate to AAFP; and Dr. Walter H. Rose of Indianola, alternate delegate.

New directors are Dr. Dayton Whites of Lucedale, Dr. Elmo Gabbert of Meadville, Dr. William Gillespie of Meridian, Dr. Jerome B. Hirsch of Greenville, and Dr. Tom Glasgow of Oxford.

Dr. Hardy Woodbridge received the John B. Howell Memorial Award for outstanding service to family medicine in Mississippi. Other awards went to Dr. Jack Hudson, outstanding senior student in medicine, and Mary Ann Frank, outstanding junior student.

Theme of the program was "Life Style Changes for Better Health." Featured speaker was Dr. Kenneth Cooper of Dallas, TX. Saturday's "Heart Day" program featured presentations by Drs. Kenneth Bennett, Quinton H. Dickerson, William Arthur Jones and McKamy Smith of Jackson, and Dr. Benjamin Carmichael of Hattiesburg.



Dr. Hardy Woodbridge of Jackson, left, received the John B. Howell Memorial Award of the MAFP at the academy's annual meeting in July. Dr. Joseph Johnston of Mount Olive, right, made the presentation.



Dr. Ken Cronin of Jackson, left, and Dr. John Hassell of Laurel display the first place trophies won during the MAFP's tennis tournament.

Medicaid Budget Hit Hardest

Experts representing butchers, bakers, candlestick makers and just about every other human enterprise under the American sun continue to tramp and tread through the maze of details contained in the historic Reagan budget reconciliation and tax cut legislation searching to better understand what's in store for whom.

Future federal spending for health care is pretty clear, however. The budget reconciliation measure cuts $2 billion in health spending over previously projected levels with most of the reductions coming to roost on the Medicaid program.

Federal matching payments will be reduced by three percent in the fiscal year starting October 1 under the budget reconciliation law. The reduction will climb to four percent in fiscal 1983 and 4.5 percent in fiscal 1984. More than $1 billion in federal payments to the states will be missing.

The budget law provides relief for states if they meet certain criteria. The federal cut could be offset by one percent each for operating a qualified hospital cost review program, having an area unemployment rate exceeding 150 percent of the national average, and sufficient recoveries from fraud and abuse activities. State-effected savings over a certain percentage also would qualify for upping federal payments.

A controversial Senate amendment that would have repealed Medicaid beneficiaries' freedom of choice of providers was tossed out in conference. Instead, the bill allows states to apply for waivers from the Health and Human Services (HHS) Secretary to eliminate freedom of choice, allowing states to direct beneficiaries to hospitals or physicians.

The law permits states to require individuals who over-utilize services to use selected providers, and allows states to limit the participation of providers found to have abused the program.

States are authorized to buy laboratory services and medical devices through competitive bidding. The HHS Department could allow states to establish cost-effective arrangements for services and drugs.

States are given the okay to enter into Medicaid prepaid risk arrangements with federally qualified health maintenance organizations (HMOs). The limitation on Medicare and Medicaid enrollment in HMOs with state Medicaid contracts is raised from 50 percent to 75 percent of the total membership.

Block Grants Will Be Back

The Reagan Administration has told the nation's governors it it committed to achieving the type of block grants favored by the governors.

HHS Secretary Schweiker, in a meeting with the governors recently, commended the governors for their support in the Administration's tangle with Congress on the block grant issue. He conceded that the result was a long way from the original goal of turning the responsibility over to the states, but promised an effort will be made next year to put more federal programs into block grants.

In acting on the Administration's proposal to place a wide range of programs into block grants, including 26 health programs, Congress gave the Administration, at best, half-a-loaf. About 20 health programs were placed in block grants in the budget reconciliation measure, and most of these were wrapped in restrictions as to how the states could spend the money.

The block grant concept is to place a group of federal programs into a single lump sum allotment to the states with the states then free to spend the money among the various programs as they choose.

Schweiker said the Administration is now working to design the block grants approved by Congress with a minimum of federal regulations so that the states will have maximum flexibility.

White House and HHS officials are beginning a series of regional conferences at all levels of government to coordinate and speed the implementation of the block grants, he said. The emphasis throughout will be on deregulation, Schweiker told the governors.

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NEW MEMBERS

Bramm, David Leroy, Centreville. Born Memphis, TN, Aug. 4, 1952; M.D., University of South Alabama School of Medicine, Mobile, 1980; interned one year, University of South Alabama Hospitals, Mobile; elected by Amite-Wilkinson Medical Society.

Chetta, Marc Anthony, Poplarville. Born Baton Rouge, LA, Dec. 30, 1953; M.D., Louisiana State University School of Medicine, New Orleans, 1978; interned and family practice residency, Tallahassee, FL, 1978-81; elected by Pearl River County Medical Society.

Davidson, Edwin Marionneaux, Gulfport. Born Plaquemine, LA, June 26, 1946; M.D., Louisiana State University School of Medicine, New Orleans, 1972; interned University of Texas Hospitals, San Antonio, one year; medicine residency, LSU and Charity Hospital, New Orleans, 1973-75; medical oncology residency, University of Missouri Medical Center, Columbia, 1975-77; elected by Coast Counties Medical Society.

Duckworth, Michael Ralph, Columbus. Born Brookhaven, MS, Mar. 13, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and internal medicine residency, UMC, Jackson, 1975-78; elected by Prairie Medical Society.

Gerald, Carolyn, Wiggins. Born Hattiesburg, MS, Oct. 26, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned UMC, Jackson, one year; elected by Coast Counties Medical Society.

Green, Richard T., Picayune. Born Cape Girardeau, MO, April 24, 1933; M.D., Tulane University School of Medicine, New Orleans, 1958; interned UMC, Jackson, one year; medicine residency, Ochsner Foundation, New Orleans, 1966-68; occupational medicine residency, University of Cincinnati, OH, 1963; elected by Pearl River Medical Society.

Holmes, Edward Harris, Meridian. Born Winona, MS, Mar. 23, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, medicine residency and fellowship in pulmonary medicine, UMC, Jackson, 1976-81; elected by East Mississippi Medical Society.

Jeter, Marvin H., Jr., Jackson. Born West Point, MS, Nov. 7, 1935; M.D., Tulane University School of Medicine, New Orleans, 1962; interned and medicine residency, UMC, Jackson, 1962-66; reinstated by Central Medical Society.

Strong, William B., Jr., Hattiesburg. Born Vicksburg, MS, Aug. 3, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned UMC, Jackson, one year; pathology residency, University of Tennessee, Memphis, 1977-78; anesthesiology residency, University of Texas, Galveston, 1978-80; elected by South Mississippi Medical Society.

PERSONALS

James L. Achord of UMC spoke to staff members at Jackson-Madison County General Hospital in Jackson, Tennessee, August 10-11.

W. Joseph Burnett of Oxford announces the association of R. Alan Davis for the practice of otolaryngology, maxillofacial surgery and facial plastic surgery.

Marc A. Chetta has opened his office for family practice at 207 West Pearl Street in Poplarville.

James E. Clarkson has opened his office for the practice of hematology and medical oncology at 127 Lameuse Street in Biloxi.

Lala Mathers Dunbar announces the opening of her office for the practice of internal medicine at 950 East Wayne Street in Waynesboro.

Lewis E. Hatten was guest speaker at the July meeting of the Hattiesburg unit of the American Diabetes Association.

William H. Hill announces the opening of his office in the Coastal Medical Center, Biloxi, for the practice of cardiology.

Sam Johnson of UMC was a featured speaker at a recent meeting of the American Association of Workers for the Blind in Toronto, Canada.

Francis S. Morrison of UMC lectured during the August meeting of the Mississippi Association of Surgical Technologists in Biloxi.

WALTER C. MOSES, JR. announces the opening of his office for the practice of internal medicine at 405 River Road in Greenwood.

MATTHEW JOHN PAGE of Greenville recently received an award for 25 years of service to mankind from Meharry Medical College.

PHILIP G. RHODES of UMC made a presentation during the August meeting of the Mississippi Association of Surgical Technologists in Biloxi.

JAMES A. SHEFFIELD and RONALD T. BRUNI of Gulfport announce the association of R. BRYANT MCCRARY in the Gulf Coast Pediatric Clinic, 0450 Pass Road.

BEVERLY ANN SMITH of Jackson announces the association of WILLIAM K. SUTHERLAND in the practice of obstetrics and gynecology at 608 Medical Arts Building.

BOBBY D. SMITH has associated with JOHN A. MCLEOD, III, KATHERINE ALDRIDGE, JOSEPH B. MCMILLON and JAMES R. HOUSE, JR. of Hattiesburg for the practice of anesthesiology.

DEATHS

HAGAMAN, A. VAN DYKE, Jackson. Born Centreville, MS, Jan. 10, 1905; M.D., Vanderbilt University School of Medicine, Nashville, 1928; interned Touro Infirmary, New Orleans, one year; EENT residency, Cleveland Clinic, Cleveland, OH, 1929-30; died Aug. 6, 1981, age 76.

RADER, BENJAMIN B., JR., Clarksdale. Born Pittsburgh, PA, June 3, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Mississippi Baptist Hospital, Jackson, one year; died July 9, 1981, age 44.

SPELL, FREDERICK KERVIN, Columbia. Born Morgantown, MS, Oct. 27, 1925; M.D., Tulane University School of Medicine, New Orleans, 1953; interned Confederate Memorial Medical Center, Shreveport, 1953-1954; general practice residency, Natchez Charity Hospital, Natchez, MS, 1954-55; ob-gyn residency, Ochsner Hospital, New Orleans, 1959-1962; died Aug. 13, 1981, age 55.

CYCLAPEN-W® (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
Otitis media caused by S. pneumoniae (formerly D. pneumoniae) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylacocci, nonpenicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.
Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.
Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d	50 mg/kg/day q.i.d
Chronic Infections	500 mg q.i.d	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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Philadelphia, Pa 19101

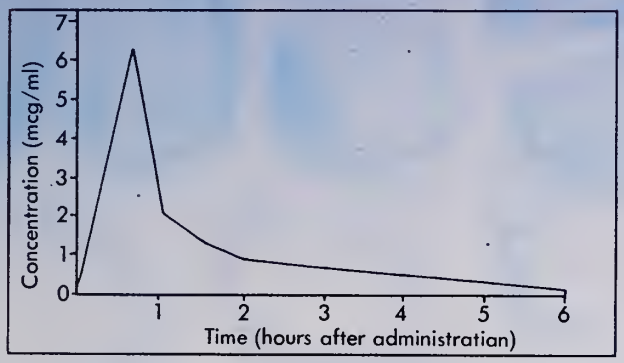
Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*



Less rash, less diarrhea than with ampicillin in studies to date.

Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

High Cure Rates with CYCLAPEN®-W (cyclacillin)		
Causative Organism	Branchitis/Pneumania†	No. af Patients
S. pneumaniae	100%	73
	95%	
Chranic Branchitis† (acute exacerbatian)		
H. influenzae	92%	12
	Though clinicol improvement has been shown, bacteriologic cures connot be expected in oll patients with chronic respiratory disease due to *H. influenzae*.	
Streptacaccal Sare Thraat†		
Graup A beta-hemolytic Streptacaccus	100%	44
	86%	
% Clinical Respanse % Bacterial Eradicatian		

†Due to susceptible orgonisms.

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CYCLAPEN®-W

(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW NAME

*Based on single aral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

See important information on facing page.

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POSTGRADUATE CALENDAR

Oct. 14-17, 1981
FAMILY PRACTICE UPDATE
Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine, the Medical Center Division of Continuing Health Professional Education and the Mississippi Academy of Family Physicians.

Coordinators: Robert C. Forbes, M.D., and Robert F. Willis, M.D., assistant professors of family medicine, University Medical Center.

This annual review for primary care physicians will feature lectures on practice-oriented topics. Brief lectures followed by question and answer periods will provide an opportunity to explore problems encountered in day-to-day care of office and hospital patients. Partial support is from the General Continuing Medical Education Fund of the Guardian Society of the University of Mississippi Alumni Association, the House Staff Continuing Medical Education Fund of the Medical Alumni Chapter, The University of Mississippi Alumni Association and Ross Labs. Fee: $125. Credit: 21.5 credit hours (2.1 CEU), Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

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Dec. 3, 1981
HEMATOLOGY IN THE NEONATE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, the Department of Obstetrics and Gynecology and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and newborn medicine division chief, and Gwen Bussa, R.N., M.N., C.N.M., assistant professor of nursing and instructor in obstetrics and gynecology (nurse-midwifery), University Medical Center.

This program will focus on the normal hematological finds and their variations in the newborn. The program is limited to ten registrants. Support is acknowledged from the General Continuing Medical Education Fund of the Guardian Society of the University of Mississippi Alumni Association. Fee: $35. Credit: 5.5 credit hours (.55 CEU), Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

Dec. 10-11, 1981
THIRD ANNUAL MISSISSIPPI PERINATAL POSTGRADUATE COURSE
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine, the Department of Pediatrics Division of Newborn Medicine, the School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: John C. Morrison, M.D., professor of obstetrics and gynecology and director of the division of maternal-fetal medicine, and Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the division of newborn medicine, University Medical Center.

This third annual program will look at new developments in perinatal medicine. Sessions include the management of pregnancy induced hypertension, intrauterine growth retardation, and

diagnosis and management of perinatal infections. The program, also open to nurses, social workers, dietitians, and technicians, will focus on the multidisciplinary approach to solving perinatal health care problems. Partial support for the program is from the Obstetrics and Gynecology Continuing Medical Education Fund of the University of Mississippi Alumni Association and a grant from Mead-Johnson and Ross Laboratories. Fee: $200 for physicians. Credit: 12.5 credit hours (1.25 CEU), Category I of the AMA Physician's Recognition Award and the American Academy of Family Physicians.

Dec. 17, 1981
NEWBORN METABOLISM — FLUIDS AND ELECTROLYTES
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, the Department of Obstetrics and Gynecology and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and newborn medicine division chief, and Gwen Bussa, R.N., M.N., C.N.M., assistant professor of nursing and instructor in obstetrics and gynecology (nurse-midwifery).

This program will define the normal fluid and electrolyte status and medications in newborns. Abnormalities and their treatment are also to be covered. The program is limited to 10 participants. Support is acknowledged from the General Continuing Medical Education Fund of the Guardian Society of the University of Mississippi Alumni Association.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

Pulmonary Disease Seminar Scheduled

A seminar on pulmonary disease will be held Nov. 12 at Forrest General Hospital. Lectures include: advances in asthma, non-ventilator management of COPD, advances in granulomatous disease, and evaluation of pneumonia. For information, write to Hattiesburg Clinic, 415 S. 28th Ave., Hattiesburg, MS 39401.

UMC Names New Faculty Members

Five new faculty members have joined the School of Medicine and centerwide faculties at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Matityahu Shaklai was named visiting associate professor of medicine. Joining the faculty as associate professor of radiology are Dr. Bharti Patel and Dr. Rameshkumar B. Patel. Lucy Hathorn Leslie was named an instructor in pediatrics (psychology), and Dr. Robert G. Carroll was named an instructor in physiology and biophysics.

Dr. Shaklai earned the M.D. degree at the Hebrew University School of Medicine, interned at Hasharon Hospital and took residency training at Beilinson Medical Center. He held a fellowship at Scripps Clinic and Research Foundation. Dr. Shaklai had been director of the division of hematology at Beilinson Medical Center and senior lecturer in hematology at Tel-Aviv University School of Medicine since 1978.

Dr. Bharti Patel had been assistant professor of internal medicine in the division of nuclear medicine at St. Louis University School of Medicine since 1980. Dr. Patel earned the M.D., took residency training at Baroda's University Hospitals and held a fellowship in nuclear medicine at Washington University.

Dr. Rameshkumar Patel earned the M.D. at the University of Baroda, interned at Baroda's University Hospitals and at South Baltimore General Hospital and took residency training at Case Western Reserve University Hospital and the University of Virginia Medical Center. Dr. Patel held a fellowship at Washington University, and had been assistant professor of radiology at St. Louis University since 1978.

Ms. Leslie earned the B.A. at Millsaps, and the M.A. and Ph.D. degrees at the University of Mississippi. She had been director of team coordination and programs at North Mississippi Retardation Center in Oxford since 1980 and was director of diagnostic services there from 1978-1980.

Dr. Carroll, a B.S. graduate of the University of Notre Dame, earned the Ph.D. at the College of Medicine and Dentistry of New Jersey. He had been a graduate assistant there since 1978.

PLACEMENT SERVICE

Physicians Wanted

ANESTHESIOLOGIST to join large community hospital. Contact Tom Askew, Administrator, Greenwood-Leflore County Hospital, Greenwood, MS 38930.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

SURGEON to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

JOIN MPAC TODAY

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

BOARD ELIGIBLE INTERNIST seeks practice location; M.D. from University of Texas at Southwestern. Contact Stephen R. Cherry, M.D., 7061 B Creekview Trail, St. Louis, MO 63123.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Baites, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

CLASSIFIED

GENERAL PRACTICE opportunity in group practice in small rural community, East Central Mississippi. Excellent hospital and office facilities. Contact: Art Nester, Administrator (601) 743-5851, Prentiss F. Keys, M.D., and J. L. Smith, M.D. (601) 743-2642.

COMPHEALTH — Locum Tenens — Physicians covering physicians, nationwide, all specialties. We provide cost effective quality care. Call us day or night. T. C. Kolff, MD, President, CompHealth, 175 W. 200 S., Salt Lake City, Utah 84101, (801) 532-1200.

200 MILLIAMPS OFFICE X-RAY UNIT, complete with table, stand and new tube, and tank developing system, pig-o-stat, x-ray file storage, mobile screen, chest plate rack, apron and accessories. $8,000. Available now. Contact Dr. Lyle, Starkville Children's Clinic, P.O. Box 1507, Starkville, MS 39759; (601) 323-7510.

CLAY ADAMS ELECTRONIC cell counter. Performs HGB, RBC, WBC; List $6,950.00 — sacrifice $3,500.00. Contact Robert T. Cates, M.D., (601) 856-6000.

EQUIPMENT FOR SALE. Like new. Flame photometer, chloride unit, coagulation unit, centrifuge, cell counter. Also GE DXS-650-II x-ray generating unit plus chest changer. Call (601) 981-1003.

114th Annual Session

May 2-6, 1982

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IN CONCLUSION

Thus far in 1981 seven states have either enacted a "child passenger protection law" for the first time or amended an existing law, according to data collected by the AMA's Department of State Legislation. Generally, the laws require that children below a specified age be properly protected, through the use of child passenger restraint systems meeting certain standards, when being transported in motor vehicles. Penalties for failure to comply with the laws vary from verbal warnings to fines.

Updated information for physicians and the lay public on the subject of DES and cancer of the female reproductive organs is provided in three free pamphlets distributed by the National Cancer Institute. "Information for Physicians" includes explanations of the population at risk and conditions found, procedures for examination and referral of daughters and mothers, an atlas of DES-type drugs, and other information. The pamphlets are available from the Office of Cancer Communications, NCI, Building 31, Room 10A19, Bethesda, MD 20205.

The number of jobs in the health care industry increased 5% in 1980, although employment in the industry as a whole increased only 0.7%, according to Health Care Financing Trends, published by the Health Care Financing Administration of HHS. The hourly wage rate went up 10%, compared to a rise of 8% for all industry. Health care workers, however, make almost $1 an hour less ($5.69) than their counterparts elsewhere ($6.66). In 1980 the health care industry employed 4.8 million people, or 5% of all industrial workers, reported HCFA.

More new dietary foods and beverages may be on the market as a result of legislative and regulatory decisions which have increased the availability of alternative sweeteners. That prediction was made in a publication of an association of manufacturers and suppliers of the products. Congress voted to extend the moratorium on the ban on saccharin; the FDA approved aspartame for sale as a tabletop sweetener and as an ingredient in foods and dry beverages; and the FDA also approved the use of polydextrose, a reduced-calorie bulking agent.

A new text presenting the latest clinical research on drug abuse is available from the AMA. Drug Abuse: A Guide for the Primary Care Physician includes chapters on causes and prevalence of drug abuse, pharmacology, diagnosis and management of acute drug reactions, medical and psychological complications; confronting and counseling drug abusers and their families, deciding when to treat and when to refer, establishing treatment plans, etc. To order, send $17.00 to Order Dept. OP-323, American Medical Association, P.O. Box 821, Monroe, WI 53566.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral form* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus, severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.
Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.
INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins*, i.e., *dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*
Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least ⅓, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.
Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.
Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.
Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam/Roche), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
INJECTABLE: Although promptly controlled, seizures may return; re-administer if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.
Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.
Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam/Roche) therapy and are of no known significance.
INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.
Dosage: Individualized for maximum beneficial effect.
ORAL—*Adults:* Anxiety disorders, relief of symptoms of anxiety, 2 to 10 mg *b.i.d.* to *q.i.d.*; acute alcohol withdrawal, 10 mg *t.i.d.* or *q.i.d.* in first 24 hours, then 5 mg *t.i.d.* or *q.i.d.* as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg *t.i.d.* or *q.i.d.*; adjunctively in convulsive disorders, 2 to 10 mg *b.i.d.* to *q.i.d. Geriatric or debilitated patients:* 2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for use under 6 months).
INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)
For dosages in infants and children see below, have resuscitative facilities available.
I.M. use: by deep injection into the muscle.
I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*
Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcoholic withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children, *administer I.V. slowly;* for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available. Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred), repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.
In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M., in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.
Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.
Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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Nutley, New Jersey 07110

Examine Me.

OCT 29 1981

NEW YORK ACADEMY OF MEDICINE

During the past several years, I have heard my name mentio in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspap magazines, and yes, best-sellers. Lately, whenever I see or hear t phrases "overmedicated society," "overuse," "misuse" and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

2 EAST 103RD ST
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For a brief summary of product information on Valium® (diazepam/Roche) ℞, please see the preceding page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

November 1981

JOURNAL of the MISSISSIPPI State Medical Association

This Month:

Surgical Management of Rectal Adenocarcinoma

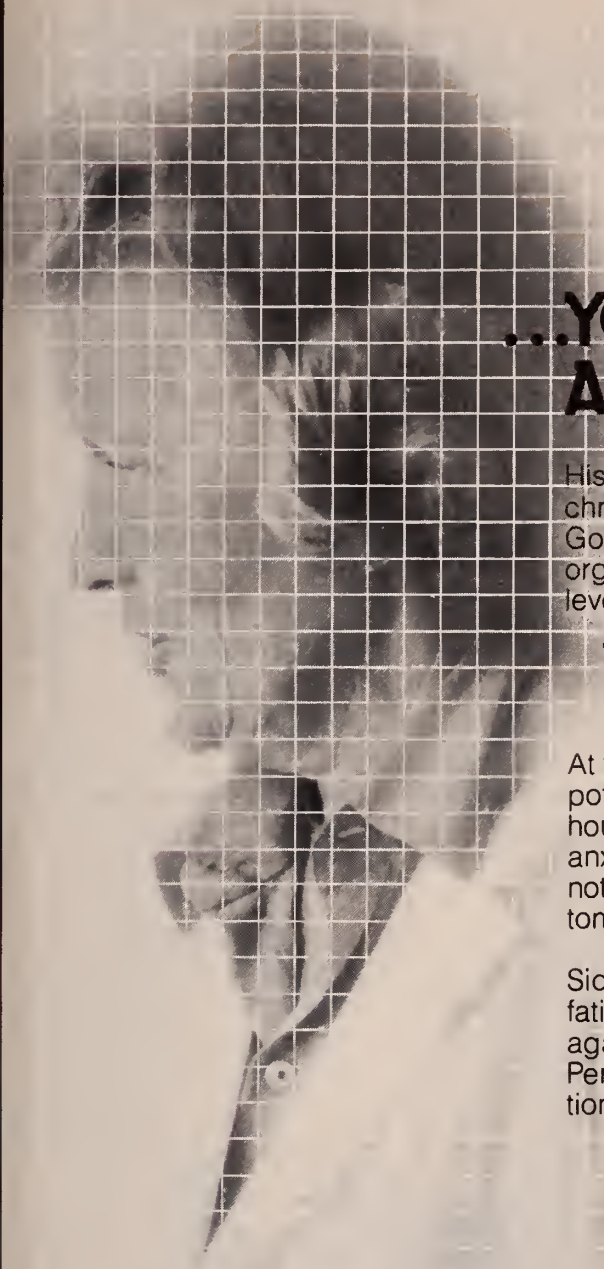
Pyopneumoperitoneum Stimulating Colon Dilatation: Computed Tomography for Abdominal Abscess Definition

Evaluation of the Adolescent for Scoliosis After Positive School Screening

The Stimulated Granulocyte as an Effector of Immune Injury or, The Fickle Phagocyte: Friend or Foe?

THE PATIENT THINKS HE HAS HEART TROUBLE...





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500,* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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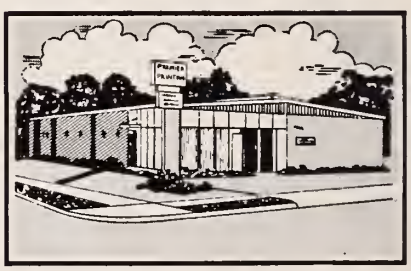
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November 1981, Volume XXII, Number 11

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

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Ru-Tuss Tablets act continuously for 10 to 12 hours.
Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.
INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.
CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated
WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.
PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings.)
OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.
ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure
DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.
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Bottles of 100 Tablets	NDC 0524-0058-01
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Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.
INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.
CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated
Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.
WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers
PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease. Caution should also be used in patients with pulmonary, hepatic or renal insufficiency
ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions
DOSAGE AND ADMINISTRATION Adults 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.
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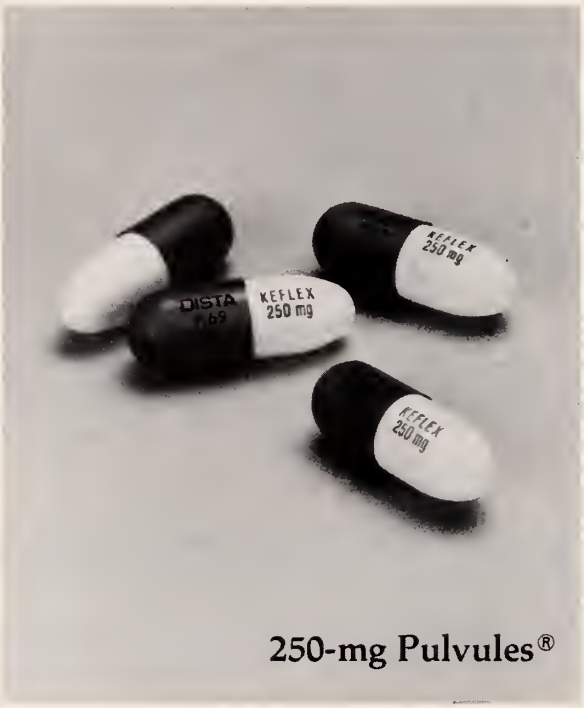
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NEWSLETTER

November 1981

Dear Doctor:

The value of house calls in provision of care to children has been neglected, says a pediatrician writing in the American Journal of Diseases of Children. Lawrence R. Berger, M.D., of the University of New Mexico School of Medicine, notes that since World War II, home visits by physicians have become unusual. He acknowledges that more patients can be seen efficiently in an office-based practice with x-ray and laboratory facilities available.

> However, he cites several cases to demonstrate that "home visits offer certain other opportunities for care and insights into family function that cannot be provided in the office or clinic." He considers home visits a valuable tool, but concludes that "by no means do all families in a pediatric practice require home visits."

Tuition at public and private medical schools is expected to rise by about 15% in the coming academic year, according to the Association of American Medical Colleges. Average annual tuition in 1981-82 is expected to be $9,108 in private medical schools (a 15% jump), $2,267 for state residents in public schools (up 13%), and $4,941 for non-residents in public schools (up 16%).

Following a directive from the Office of Management and Budget, the Department of HHS has developed "management efficiencies" to streamline operation of the Public Health Service commissioned corps. Included are proposals to give the secretary of HHS discretion in distributing retention special pay and proposals to prohibit physicians in the NHSC from becoming commissioned officers.

Medical costs outpaced increases in the general inflation rate for the first seven months of 1981. While the overall CPI climbed at an annual rate of 9.4%, medical care costs increased by 12.6% (housing was up 12.1%; food and beverage 2.7%). During the period, hospital room charges rose 13.6% (13% last year) and physicians' fees climbed 12.8% (same as last year).

Following action by the AMA House of Delegates this year, new dues standards will become effective in 1982. MSMA/AMA members over age 70 and retired from medical practice and members experiencing financial hardship will continue to be exempt from dues; but age or retirement alone have been eliminated as a cause for dues exemption.

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor

New from Janssen Pharmaceutica: Introducing a promising new approach to histoplasmosis therapy

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Bottom: After 90 days oral NIZORAL therapy.

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Effective:

"...ketoconazole may prove to be the drug of choice for...histoplasmosis."[1]

Clinical trials employing 200-400 mg NIZORAL per day have shown a combined response rate* of 84% after 10 (median) weeks of therapy.[2] In a recent study in normal (not immunocompromised) hosts, 6 out of 7 patients with progressive cavitary histoplasmosis achieved clinical and radiographic cures after 100 days on 200 mg ketoconazole per day.[2] (Recommended minimum treatment is 180 days.)

Safe:

"...can be safely administered for prolonged periods..."[3]

Freedom from long-term toxicity permits use of extended therapeutic courses of NIZORAL, when indicated, and provides an extra margin of safety in presumptive antifungal therapy. Long-term administration has revealed no organ toxicity and no consistent changes in important hematological or biochemical values. Infrequent, transient increases in serum liver enzymes have been seen. Adverse reactions were generally minor and only rarely required withdrawal of therapy.

Convenient:

once-a-day oral regimen fosters compliance...facilitates use both in and out of the hospital.

*Includes cases in remission or markedly improved (no evidence of active disease); both mycological and clinical criteria were considered in measuring overall response.

For further information on NIZORAL write: Professional Services, Janssen Pharmaceutica Inc., 501 George St., New Brunswick, N.J. 08903.

See the facing page for Complete Prescribing Information.

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JPI-210

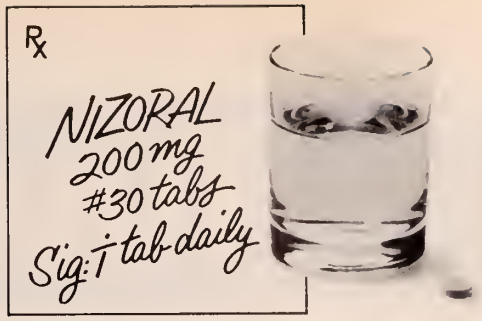
JANSSEN PHARMACEUTICA

NEW orally effective

NIZORAL™ TABLETS

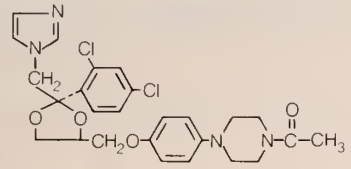
(ketoconazole)

One tablet a day provides broad-spectrum antimycotic efficacy



DESCRIPTION

NIZORAL™ (ketoconazole) is a synthetic broad-spectrum antifungal agent available in scored white tablets, each containing 200 mg ketoconazole. Ketoconazole is *cis*-1-acetyl-4-[4-[[2-(2,4-dichlorophenyl)-2-(1*H*-imidazol-1-ylmethyl)-1,3-dioxolan-4-yl]methoxy]phenyl]piperazine and has the following structural formula:



NIZORAL™ is a white to slightly beige, odorless powder, soluble in acids, with a molecular weight of 531.44.

CLINICAL PHARMACOLOGY

Mean peak plasma levels of approximately 3.5 μg/ml are reached within 1 to 2 hours, following oral administration of a single 200 mg dose taken with a meal. Subsequent plasma elimination is biphasic with a half-life of 2 hours during the first 10 hours and 8 hours thereafter. Following absorption from the gastrointestinal tract, NIZORAL™ is converted into several inactive metabolites. The major identified metabolic pathways are: oxidation and degradation of the imidazole and piperazine rings, oxidative O-dealkylation and aromatic hydroxylation. About 13% of the dose is excreted in the urine, of which 2 to 4% is unchanged drug. The major route of excretion is through the bile into the intestinal tract. *In vitro*, the plasma protein binding is about 99%, mainly to the albumin fraction. Only a negligible proportion of NIZORAL™ reaches the cerebral spinal fluid. NIZORAL™ is a weak dibasic agent and thus requires acidity for dissolution and absorption.

NIZORAL™ is active against clinical infections with *Candida* spp., *Coccidioides immitis*, *Histoplasma capsulatum*, *Paracoccidioides brasiliensis*, and *Phialophora* spp. Development of resistance to NIZORAL™ has not yet been reported.

The following preclinical data are available; however, their clinical significance is unknown. NIZORAL™ is active *in vitro* against dermatophytes, dimorphic fungi, eumycetes, yeasts, actinomycetes, phycomycetes and various other fungi. In animal models, activity has been demonstrated against *Candida* spp., dermatophytes (*Trichophyton* spp., *Microsporum* spp., *Epidermophyton floccosum*), *Blastomyces dermatitidis*, *Histoplasma capsulatum*, *Malassezia furfur*, *Coccidioides immitis*, and *Cryptococcus neoformans*.

Mode of Action: *In vitro* studies suggest that NIZORAL™ impairs the synthesis of ergosterol, which is a vital component of fungal cell membranes. Tests in animals suggest this mechanism is not important in mammalian cells.

INDICATIONS AND USAGE

NIZORAL™ is indicated for the treatment of the following fungal infections: candidiasis, chronic mucocutaneous candidiasis, oral thrush, candiduria, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis. NIZORAL™ should not be used for fungal meningitis because it penetrates poorly into the cerebral-spinal fluid.

For the initial diagnosis, the infective organism should be identified, however, therapy may be initiated prior to obtaining laboratory results.

CONTRAINDICATIONS

NIZORAL™ is contraindicated in patients who have shown hypersensitivity to the drug.

WARNINGS

In female rats treated three to six months with ketoconazole at dose levels of 80 mg/kg and higher, increased fragility of long bones, in some cases leading to fracture, was seen. The maximum "no-effect" dose level in these studies was 20 mg/kg (2.5 times the maximum recommended human dose). The mechanism responsible for this phenomenon is obscure. Limited studies in dogs failed to demonstrate such an effect on the metacarpals and ribs.

PRECAUTIONS

General: In four subjects with drug-induced achlorhydria, a marked reduction in NIZORAL™ absorption was observed. NIZORAL™ requires acidity for dissolution. If concomitant antacids, anticholinergics, and H_2-blockers are needed, they should be given at least two hours after NIZORAL™ administration. In cases of achlorhydria, the patients should be instructed to dissolve each tablet in 4 ml aqueous solution of 0.2 N HCl. For ingesting the resulting mixture, they should use a glass or plastic straw so as to avoid contact with the teeth. This administration should be followed with a cup of tap water.

Drug Interactions: There is no evidence for clinically significant interaction with oral anticoagulant or oral hypoglycemic agents.

Carcinogenesis, Mutagenesis, Impairment of Fertility: The dominant lethal mutation test in male and female mice revealed that single oral doses of NIZORAL™ as high as 80 mg/kg produced no mutation in any stage of germ cell development. The Ames' *Salmonella* microsomal activator assay was also negative.

Pregnancy: Teratogenic effects: *Pregnancy Category C*. NIZORAL™ has been shown to be teratogenic (syndactylia and oligodactylia) in the rat when given in the diet at 80 mg/kg/day, (10 times the maximum recommended human dose). However, these effects may be related to maternal toxicity, evidence of which also was seen at this and higher dose levels.

Nonteratogenic effects: NIZORAL™ has also been found to be embryotoxic in the rat when given in the diet at doses higher than 80 mg/kg during the first trimester of gestation.

In addition, dystocia (difficult labor) was noted in rats administered NIZORAL™ during the third trimester of gestation. This occurred when NIZORAL™ was administered at doses higher than 10 mg/kg (higher than 1.25 times the maximum human dose).

It is likely that both the malformations and the embryotoxicity resulting from the administration of NIZORAL™ during gestation are a reflection of the particular sensitivity of the female rat to this drug. For example, the oral LD_{50} of NIZORAL™ given by gavage to the female rat is 166 mg/kg, whereas in the male rat the oral LD_{50} is 287 mg/kg.

Nursing Mothers: Since NIZORAL™ is probably excreted in the milk, mothers who are under NIZORAL™ treatment should not breast-feed the child.

Pediatric Use: Safety in children under two years of age has been documented in a limited number of cases.

ADVERSE REACTIONS

NIZORAL™ is usually well tolerated. Most adverse reactions reported have been mild and transient and have only rarely required withdrawal of therapy.

The most frequent adverse reactions were nausea and/or vomiting, which occurred in approximately 3% of patients. Abdominal pain was reported in approximately 1.2% of patients; pruritus in approximately 1.5% of patients. The following have been reported in less than 1% of patients: headache, dizziness, somnolence, fever and chills, photophobia, and diarrhea. Infrequent, transient increases in serum liver enzymes have been seen.

OVERDOSAGE

In the event of accidental overdosage, supportive measures, including gastric lavage with sodium bicarbonate, should be employed.

DOSAGE AND ADMINISTRATION

Adults: The recommended starting dose of NIZORAL™ is a single daily administration of 200 mg (one tablet). In very serious infections or if clinical responsiveness is insufficient within the expected time, the dose of NIZORAL™ may be increased to 400 mg (two tablets) once daily.

Children:

Children weighing 20 kg or less: . . . . . 50 mg (¼ tablet) once daily
Children weighing 20-40 kg: . . . . . 100 mg (½ tablet) once daily
Children weighing over 40 kg: . . . . . 200 mg (1 tablet) once daily

Generally, treatment should be continued until all clinical and laboratory tests indicate that active fungal infection has subsided. Inadequate periods of treatment may yield poor response and lead to early recurrence of clinical symptoms. Minimum treatment for candidiasis is one or two weeks. Patients with chronic mucocutaneous candidiasis usually require maintenance therapy. Minimum treatment for the other indicated systemic mycoses is six months.

HOW SUPPLIED

NIZORAL™ is available as white, scored tablets containing 200 mg of ketoconazole debossed "JANSSEN." They are supplied in bottles of 60 tablets.

U.S. Patent Pending — May 1981
NDC 50458-220-06 (60 tablets)

Manufactured by:
Janssen Pharmaceutica n.v
B-2340 Beerse, Belgium

For:
Janssen Pharmaceutica Inc.
New Brunswick, New Jersey 08903 USA

References:

1. Negroni R, Robles AM, Arechavala A, et al: Ketoconazole in the treatment of paracoccidioidomycosis and histoplasmosis. *Reviews of Infectious Diseases* 2 (4): 643-648, 1980. **2.** Data on file, Janssen Pharmaceutica. **3.** Graybill JR, Lundberg D, Donovan W, et al: Treatment of coccidioidomycosis with ketoconazole: Clinical and laboratory studies of 18 patients. *Reviews of Infectious Diseases* 2 (4): 661-673, 1980.

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because so much remains to be done.

JANSSEN PHARMACEUTICA

Janssen Pharmaceutica Inc., 501 George St., New Brunswick, N.J. 08903

Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness, emotional problems, or substance abuse, it is the only hospital of its kind in the state.

Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

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Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

DATELINE

Eliminating Measles Is 1982 Goal

Jackson, MS - The Immunization Program of the State Board of Health has begun the final phase toward elimination of indigenous measles by October 1, 1982. During this phase the SBH will increase surveillance of rash-fever illnesses through active contact with physicians and medical facilities likely to see patients with symptoms suggestive of measles. The program also depends on voluntary reporting of suspected cases by the general public, educational facilities, and the medical community.

Supreme Court Hears AMA Challenge

Chicago, IL - The assault on the AMA's ethical guidelines by the FTC violates the First Amendment and undermines efforts to protect the public from exploitation and deception, the association told the U. S. Supreme Court in a brief challenging the FTC's 1979 decision on physician advertising and contract practice. The brief points to a 1977 high court statement that the professions have a "special role to play" in "defining the boundary between deceptive and nondeceptive advertising."

SBH Considers Fee System

Jackson, MS - The Mississippi State Board of Health has approved a pilot project to test the possibility of charging a fee for health services that now are administered free. Among the services targeted are prenatal care, pediatric care and sterilizations. Programs treating hypertension, diabetes, heart disease and neurological problems are also included. Recent federal and state cutbacks have created the need for the proposed sliding-scale fee system.

AAFP Launches "Aging" Campaign

Kansas City, MO - The American Academy of Family Practice has launched a major public relations campaign to make the public aware of the family physician's role in caring for the elderly. According to figures from the AAFP, 41.9% of all office visits by patients age 65 and older are handled by family physicians or general practitioners. During 1981 over 1,800,000 Americans will join the over-65 group, at the rate of some 5,000 per day, with improved prospects for good health.

Watch For Annual Session News

Jackson, MS - Future issues of Journal MSMA and the regular editions of the MSMA "Blue Sheet" will contain details of the upcoming 114th Annual Session, to be held in Biloxi, May 2-6, 1982. The 14 scientific sections are now assembling scientific programs, and specialty societies and alumni groups are making plans for meetings. Included in special activities for this year are a special 125th anniversary party and tennis, golf, fishing and jogging events.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*



PAIN AND TENSION...
Double fault for weekend warriors

ACE THE ACHE
with

Equagesic®
(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*__INDICATIONS__: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified the indications as follows:
"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

__CONTRAINDICATIONS__: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

__WARNINGS__: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.
USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

__PRECAUTIONS__: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g. caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

__ADVERSE REACTIONS__: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.
Mild reactions are characterized by an itchy urticanal or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped and reinstitution of therapy should not be attempted.
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.
Impairment of accommodation and visual acuity has been reported rarely.

__OVERDOSE__: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

__DESCRIPTION__: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, PA 19101



for mild to moderate pain

Wygesic®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATIDN: For the relief of mild-to-moderate pain
CDNTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
USAGE IN AMBULATDRY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks e g driving a car or operating machinery Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore propoxyphene should not be used in pregnant women unless in the judgement of the physician, the potential benefits outweigh the possible hazards
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group
PRECAUTIDNS: Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients some of these reactions may be alleviated if the patient lies down
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache weakness euphoria dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported
DRUG INTERACTIDNS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**)
Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
MANAGEMENT OF DVERDDSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma pupillary constriction, and circulatory collapse In addition to these characteristics which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea cardiac arrest, and death have occurred
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting anorexia and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity, jaundice coagulation defects hypoglycemia, encephalopathy, coma and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists naloxone, nalorphine and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen, IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia nausea vomiting, and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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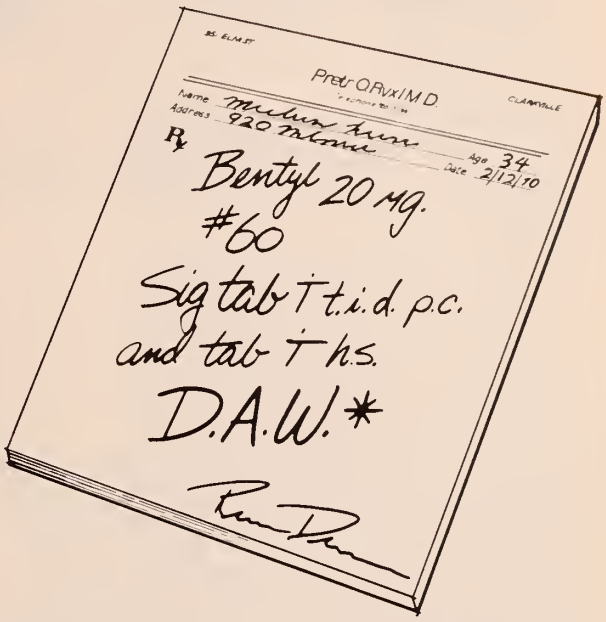
...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl®

(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



*D.A.W.-Dispense as written

because:

- The Bentyl molecule is a product of original Merrell research.
- At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- Significant pharmacologic effect in the distal colon compared to placebo,[1] shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:
1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage severe ulcerative colitis, toxic megacolon complicating ulcerative colitis myasthenia gravis

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect No known deaths or permanent adverse effects have been reported Bentyl syrup should be used with caution in this age group

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy

Use with caution in patients with

Autonomic neuropathy Hepatic or renal disease Ulcerative colitis Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition

Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia, nausea vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations, some degree of mental confusion and or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs

Usual Dosage

Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (Dilute with equal volume of water)

Bentyl 20 mg *Adults* 1 tablet three or four times daily

Bentyl Injection *Adults* 2 ml (20 mg) every four to six hours intramuscularly only
NOT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used

Product Information as of July, 1980

Injectable dosage forms manufactured by
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Swiftwater, Pennsylvania 18370 or
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
November 1981, Vol. XXII, No. 11

ORIGINAL PAPERS

Surgical Management of Rectal Adenocarcinoma

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

In 1908 William Earnest Miles reported 12 cases in which abdominoperineal resection was performed for carcinoma of the rectum.[1] He was concerned about the high mortality rate (41.6%) but hastened to point out that without operation, it would have been 100%. This represented the first attempt at removal of the primary rectal tumor along with the zones of metastatic spread. Prior surgical efforts were concerned only with removal of the primary growth. En bloc removal included the rectum, perirectal fat and contained vascular and lymphatic tissue. Perhaps the single most important contribution made by Miles was his emphasis upon the upward route of lymphatic spread along the superior hemorrhoidal artery and to nodes in the area of the left ileac artery. For more than 40 years this operation was used extensively for carcinoma of the rectum, rectosigmoid and lower sigmoid colon. A permanent colostomy was accepted as a necessary evil in exchange for an opportunity to be cured of cancer.

Sphincter Saving Procedures

Coller, Kay and MacIntyre in 1940 published one of several reports concerning the characteristics of lymphatic spread of carcinoma of the rectum.[2] They observed that adenocarcinoma of the rectum spreads only in an upward direction and not along the lateral and inferior lymphatic pathways, which drain the rectum.

They concluded that the lateral and inferior zones are involved only after the upward route is blocked by tumor cells, as may occur in advanced stages of the disease.

These considerations were operative in motivating surgeons to re-examine the rationale for removing extensive segments of apparently normal rectum and relegating the patients to a lifetime of existence with a colostomy.

The last several decades have provided considerable clarification of the natural history and behavior of adenocarcinoma of the rectum. Lymphatic routes of spread along with the details of intramural extension of tumors constitute important considerations in defining proper surgical procedures. Improved surgical techniques, including the introduction of stapling devices, now permit lower colorectal anastomoses and avoidance of permanent colostomy in many cases of middle-third rectal cancer. These improvements appear to be achievable without sacrificing chances for long-term eradication of the disease.

Dixon and associates at the Mayo Clinic must be credited with the initial surgical leadership toward establishing the rightful place of anterior resection.[3] It is appropriate at this juncture to distinguish between high and low anterior resection. The early efforts were concerned with high anterior resection and primary anastomosis for lesions in the low sigmoid colon and at the rectosigmoid level. The anastomosis here involves a distal stump, which is cov-

From the Department of Surgery, Mississippi Baptist Medical Center, Jackson, MS

ered by peritoneum for two-thirds to three-fourths of its circumference. It amounts to a technical exercise very similar to an intra-abdominal, end-to-end colon anastomosis. With high anterior resection there is an excellent prospect for cure, a low incidence of complications, normal to near normal bowel function and much less morbidity than with the Miles abdominoperineal resection. In contrast, low anterior resection necessitates anastomosis to a rectal stump which has no serosal covering. Questions regarding the adequacy of low anterior resection as a cancer operation have been very much in evidence. A higher incidence of anastomosis leakage can be expected, and the technical challenge for completing the anastomosis can be enormous. It is therefore understandable that the level at which anterior resection is attempted comprises a consideration of paramount importance.

Colorectal Anastomosis or Permanent Colostomy?

The consideration of first priority in the surgical management of carcinoma of the rectum must always be the complete removal of the malignant growth and the provision of a long term cure. If this necessitates a permanent colostomy, then so be it. Nevertheless, these tenets should never minimize the surgeon's efforts to accomplish a worthy cancer operation and to preserve normal rectal function at the same time. It is accurate to state that over the years of the past decade, much progress has been made toward avoiding permanent colostomy for many patients, without compromising chances for prevention of recurrence of the disease. For the purpose of this discussion, it is helpful to divide the rectum into the upper, middle and lower one-thirds (see Figure 1). Precise definitions applicable to all patients are impossible because of variations related to height, body habitus and sex. During proctosigmoidoscopic examination, the anal canal may be considered to extend 3.5 cm from the anal verge. The upper limit of the lower one-third of the rectum would be at approximately 7.5 cm. The upper boundary of the middle one-third of the rectum would be at 12 cm, while the same level for the upper one-third would lie at 16 cm.

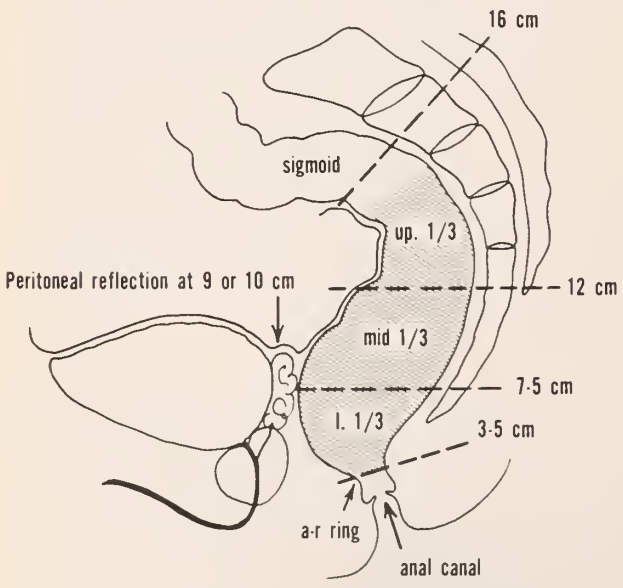


Figure 1. Helpful rectal measurements from the proctoscopic view.

Cancer of the distal rectum is characterized by an inherently poorer prognosis than the middle and upper rectum. Lesions located up to 5 to 6 cm from the anal verge are not suitable candidates for sphincter conservation operations. In general, these patients are advised to have an abdominoperineal excision.

Those rectal lesions located between 12 and 16 cm from the anal verge are suitable for anterior resection, with very few exceptions. The high anterior resection is employed and the results are good in the great majority of instances. No temporary colostomy is needed, convalescence is usually smooth, and subsequent bowel function is normal.

Rectal lesions situated between 6 and 11 cm from the anal verge continue to generate controversy in regard to the best method of management. One of the points of contention relates to the length of normal rectum, which should be removed distal to the lesion. At one time, it was considered that 2.5 cm was sufficient.[4] Subsequent reports of recurrence of malignant tumor in the suture line aroused considerable concern in regard to a distal margin of such narrow porportions.[5, 6] Grinnell's classic study, involving 93 resected tumors, revealed that retrograde spread in the lymphatics of the submucosa had occurred up to 4 cm in some specimens.[7] These findings support the wisdom of removing at least 5 cm of normal rectum beyond the lower margin of the growth. The final determination regarding the ultimate level of the growth must await freeing of the rectum from the concavity of the sacrum during operation.[8] Division of the lateral ligaments and extensive mobilization down to the levator muscles will usually allow a lesion to rise 5 cm from its position observed during proctoscopic examination. As a general rule, a lower anterior resection is more

feasible in lean patients than in the obese. The wider female pelvis facilitates a lower anastomosis than the narrow male pelvis. Other important factors involved in the decision to attempt a colorectal anastomosis include nonbulky tumors, invasion of adjacent organs, and whether or not the tumor is poorly differentiated. Thus, in borderline rectal lesions, the appropriate selection of a procedure must be made during the operation, after all parameters have been evaluated. It is also sufficient to realize that the skill and experience of the surgeon, the support of his operating theater and the adequacy of his assistants all represent significant determinants.

Temporary Colostomy

A successful colorectal anastomosis must be characterized by an adequate blood supply, a generous lumen, meticulous hemostasis in the pelvis, absence of tension and accurate approximation of colon and rectal margins. Even with fulfillment of these requisites, the lack of a serosal cover about the rectum and the usual disparity between the lumen of the colon and rectum contribute to vulnerability of this anastomosis. Where any concern exists, a temporary transverse colostomy should be done. Elective closure 6 to 8 weeks later is attended by much less stress for the patient than emergency colostomy 7 to 10 days postoperative for a leaking anastomosis and pelvic abscess. It is my preference to position a penrose drain in the pelvis during operation, but this item, of course, is characterized by a considerable difference of opinion.

Stapling Devices

The end-to-end EEA stapler has recently become available. Its construction and characteristics are particularly appropriate for use during colorectal anastomosis. The instrument is introduced through the rectum by an assistant after the two bowel segments have been freed and prepared with a purse string suture. The two bowel ends are joined by two staggered rows of staples, which provide an inverted anastomosis (see Figures 2, 3 and 4). All basic requirements for a successful anastomosis must be honored, as with the hand-sewed technique. Considerable practice and experience is necessary before optimal utilization of the EEA stapler can be achieved. Our experience with the device has resulted in the conclusion that it affords several advantages over the suture technique for low anterior anastomosis. The precision with which the staples are

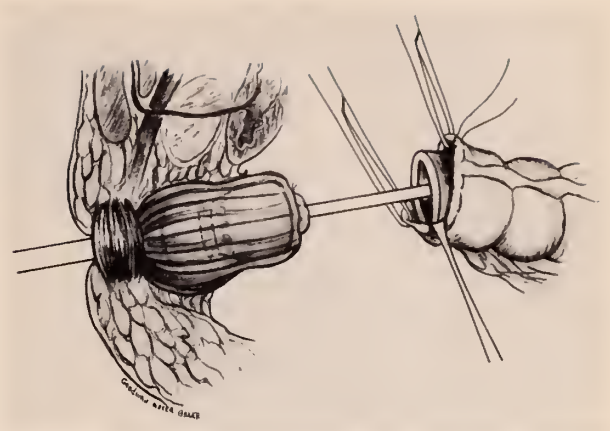


Figure 2. EEA introduced through the rectum and into the colon.

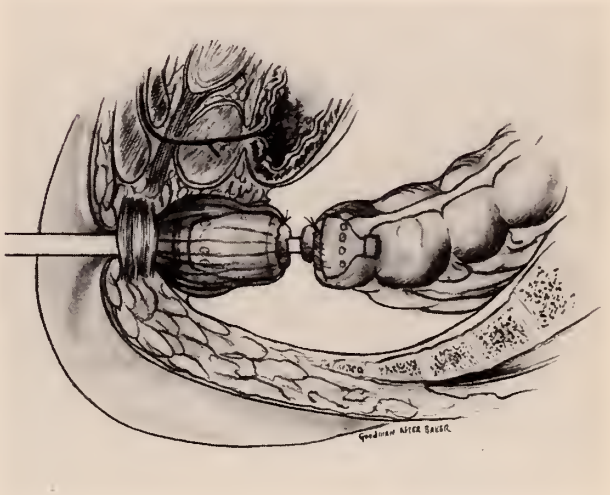


Figure 3. Purse strings sutures tied in order to secure fixation of each extremity of the EEA to the colon and rectum.

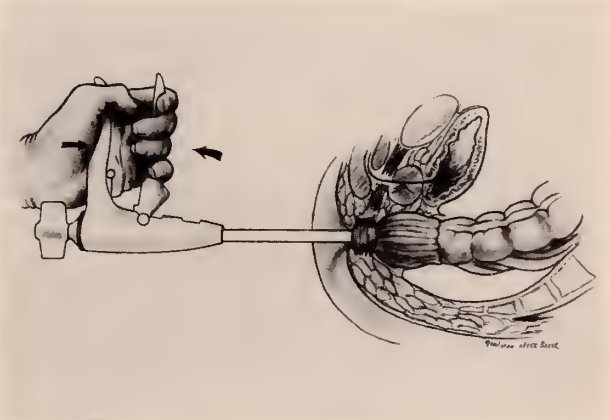


Figure 4. Colorectal approximation has been accomplished and the instrument is being fired.

laid down around the anastomosis exceeds that which can be accomplished with sutures. Less bowel wall is inverted. With experience, considerable time can be saved utilizing the EEA. It is very probable that the instrument enables the surgeon to achieve a lower colorectal anastomosis than could otherwise be accomplished. It must be firmly emphasized that many problems, technical mishaps and general misadventures can beset the surgeon, especially during his earlier experiences with the stapling instruments. Sound principles for cancer surgery must not be violated in deference to a desire to use the stapling instruments and avoid a permanent colostomy. With increasing experience and the passage of time, it is very likely that stapling devices will come to enjoy a helpful and permanent role in the management of tumors of the rectum.

Summary

Since the turn of the century, much progress has been made in the surgical management of carcinoma of the rectum. This improvement has resulted from a better understanding of the natural history and behavior of the lesions, including their routes of spread. More efficient surgical techniques now allow lower colorectal anastomoses, thus sparing the patient a permanent colostomy. This can be achieved without jeopardizing chances for a permanent cure. The recent availability of surgical stapling devices hold additional promise of benefit for the patient by allowing more rapid, precise colorectal anastomosis at even lower levels. ★★★

440 E. Woodrow Wilson (39216)

References

1. Miles, W. E.: A method of performing abdominoperineal excision for carcinoma of the rectum and of the terminal portion of the pelvic colon. Lancet 2:1812-1813, 1908.
2. Collier, F. A., Kay, E. B. and MacIntyre, R. S.: Regional lymphatic metastasis of carcinoma of the rectum. Surgery 8:294, 1940.
3. Dixon, C. F.: Preferable anterior resection of carcinoma low in sigmoid and rectosigmoid. Surgery 15:367, 1944.
4. Wangensteen, O. H.: Primary resection of rectal ampulla for malignancy with preservation of sphincter function. Surg. Gyn. Obst. 81:1, 1945.
5. Goligher, J. C.: Resection and restoration of continuity in the treatment of carcinoma of the rectum. Postgrad. Med. J. 27:568, 1951.
6. Enker, W. E. and Decosse, J. J.: The evolving surgical treatment of rectum and colon cancer. CA J. for Clinicians 31:66, 1981.
7. Grinnell, R. W.: Distal intramural spread of carcinoma of the rectum and rectosigmoid. Surg. Gyn. Obst. 99:421, 1954.

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
Otitis media caused by S. pneumoniae (formerly D. pneumoniae) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.
Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cepholosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY. Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.
Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days* treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d body weight ≥ 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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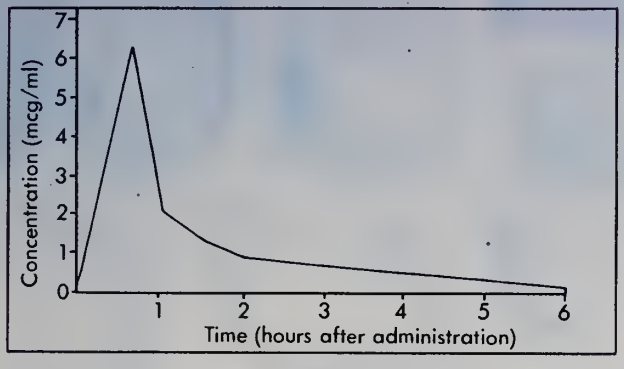
Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*



Less rash, less diarrhea than with ampicillin in studies to date.

Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

High Cure Rates with CYCLAPEN®-W (cyclacillin)		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100%	73
	95%	
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92%	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.	
Streptacoccal Sore Throat†		
Group A beta-hemolytic Streptococcus	100%	44
	86%	
% Clinical Response % Bacterial Eradication		

†Due to susceptible organisms.

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Radiologic Seminar CCXVIII: Pyopneumoperitoneum Simulating Colon Dilatation: Computed Tomography for Abdominal Abscess Definition

PHILIP E. CRANSTON, M.D. and JAMES L. BURKHALTER, M.D.
Jackson, Mississippi

INTRA-ABDOMINAL ABSCESS DETECTION and treatment are critical for patient survival.[1-5] Plain film evaluation of abdominal abscess formation is fraught with many problems, among which are low sensitivity and nonspecificity.[6, 7] Nearly half of abdominal abscesses are missed by routine radiographic exams.[5] Diagnosis with conventional x-rays depends on demonstration of mass density change, mass effects, silhouetting signs, and extraluminal gas detection.[5] Abscesses can mimic bowel and bowel contents. Colon gas and fecal material are notorious imposters of abscess change. This case demonstrates how a large pyopneumoperitoneum mimicked colon dilatation and was defined by computed tomography (CT) scanning.

Case Report

A 50-year-old black woman initially presented with a syncopal episode attributed to anemia secondary to gastrointestinal hemorrhage from an undetermined site. Her hospital course was protracted, including eventually two endoscopies, four angiograms, and three surgical procedures within three months. Three weeks after the third operative procedure and following 10 days of intravenous Nebcin and Keflin she became febrile with temperature of 103° F, lethargic, and distended. Previous liver biopsy had demonstrated Laennec's cirrhosis, and clinically it was felt that she had developed ascites. Plain radiographs of the abdomen revealed huge homogeneous collections of intra-abdominal gas along both flanks and extending into the pelvis with superimposed smaller, mottled gas collections; radiographically a distal colon obstruction was suspected (see Figure 1). A CT examination was per-



Figure 1. Large homogeneous gas collections in both flanks with superimposed smaller innumerable gas bubbles simulate a distal colon obstruction.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi Medical Center, Jackson, MS.

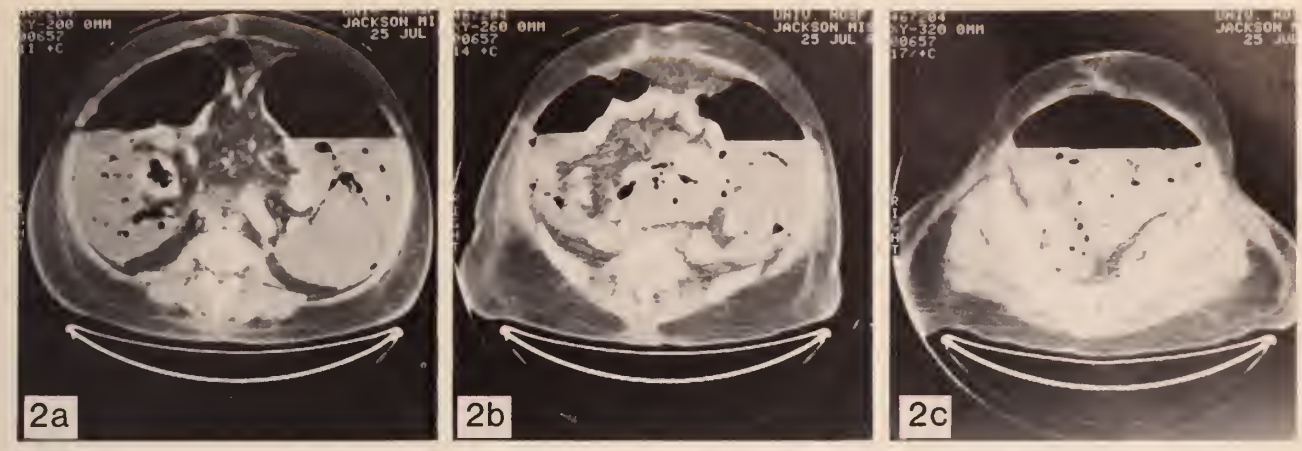


Figure 2 (a,b,c). Abdominal CT scan reveals the intestine to be compressed in the midline by a large pyopneumoperitoneum involving both sides of the abdomen and the pelvis.

formed utilizing dilute gastrografin in the gastrointestinal tract; this demonstrated a large intra-abdominal collection of extraluminal gas layering above smaller, innumerable mottled gas collections which were clearly separated from and compressing toward the midline the large and small intestine (see Figure 2a-c). It was felt that this represented a large intra-abdominal abscess formation extending along both flanks and into the pelvis. Subsequently a gastrografin enema proved the colon to be of normal size (see Figure 3).

At surgery approximately five liters of purulent material were drained from what was described as an intra-abdominal "horseshoe-shaped abscess." Postoperatively the patient did well, and a follow-up CT abdominal scan showed complete resolution of the abscess.



Figure 3. Gastrografin enema confirms that the colon is of normal size with a significant amount of extraluminal gas and soft tissue density representing the massive pyopneumoperitoneum.

Discussion

Intra-abdominal abscesses can prove quite difficult to accurately diagnose; the common pitfalls result from several factors. Plain film findings can often be subtle, consisting of mass effect, silhouetting signs, and extraluminal gas collections.[5] Mass effects on plain films and CT scan can be due to normal structures which, if not outlined by contrast medium, can be mistaken for an abnormal mass density.[8]

Extraluminal gas collection — the hallmark of abscess formation — can be either small collections of gas bubbles which are difficult to separate from small intestine or colonic content[5] or a homogeneous collection of intra-abdominal gas,[9] which in our case was massive and mimicked a distal colon obstruction.

CT has now been shown to be efficacious for abdominal abscess evaluation, particularly with the fast scanners now in use.[2, 3, 10] The ability to rapidly diagnose abdominal abscess formation outweighs the cost of CT scanning and should therefore reduce the overall hospital stay cost.[7] CT is now considered the primary modality of choice for intra-abdominal abscess evaluation, particularly with the acutely ill patient.[5, 11] Ultrasound and gallium scans are used as supplementary and complementary.[6, 12] The abscess on CT will appear as a mass. This may have a

homogeneous soft tissue density, although most intra-abdominal abscesses have been demonstrated to have a low density change with or without enhancing rim effect.[1, 4, 11] Fascial plain thickening has been described recently as a sign of intra-abdominal abscess formation.[11] An extraluminal mass with air or an air/fluid level is felt to be pathognomonic.[1, 4, 13] When a low density mass lesion is noted without definite demonstration of extraluminal gas, the differential diagnosis includes seromas, endometriomas, ascitic fluid, cysts of all types, hematomas, lymphoceles, urinomas, bile collections, necrotic neoplasms, pseudocyst, and even normal bowel.[2, 5, 12] Arrival at final diagnosis requires correlation with the clinical circumstances.[7] Aspiration is now being widely used to make a definite diagnosis short of surgery.[2] Catheter drainage can also be performed for treatment if the patient is believed to be a good candidate for this type of procedure.[1, 2]

Plain film radiographs often can be the definitive modality for abscess detection. The use of ultrasound, gallium scanning and CT can be avoided altogether in some cases.[14] Even if the diagnosis is known, the addition of CT scanning allows the exact localization and definition of extent of the abscess so treatment can be properly and effectively instituted.[1, 2, 3, 12] In our case CT was useful in demonstrating not only the extent of the abscess but also a normal caliber colon and in effectively ruling out a distal colon obstruction as a cause of the plain film finding. In addition, after treatment, CT scanning can provide the best method for determining treatment adequacy.[15] ★★★

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References

1. Stephens, D. H., Williamson, Jr., B., Sheedy, P. F., Hattery, R. R. and Miller, W. E.: Computed tomography of the retroperitoneal space. Radiol. Clin. North Am. 15:386, 1977.
2. Haaga, J.R., Alfidi, R. J., Havrilla, T. R., Cooperman, A. M., Seidelman, F. E., Reich, N. E., Weinstein, A. J. and Meaney, T. F.: Aspiration of abdominal abscesses. AJR 128:465-474, 1977.
3. Korobkin, M., Callen, P. W., Filly, R. A., Hoffer, P. B., Shimshak, R. R. and Kressel, H. Y.: Comparison of computed tomography, ultrasonography, and gallium-67 scanning in the evaluation of suspected abdominal abscess. Radiology 129:89-93, 1978.
4. Callen, P. W.: Computed tomographic evaluation of abdominal and pelvic abscesses. Radiology 131:171-175, 1979.
5. Halber, M. D., Daffner, R. H., Morgan, E. L., Trought, W. S., Thompson, W. M., Rice, R. P. and Korobkin, M.: Intra-abdominal abscess: Current concepts of radiologic evaluation. AJR 133:9-13, 1979.
6. Levitt, R. G., Biello, D. R., Sagel, W. W., Stanley, R. J., Aronberg, O. J., Robinson, M. L. and Siegel, B. A.: Computed tomography and 67 Ga. citrate radionuclide imaging for evaluating suspected abdominal abscess. AJR 132:529-534, 1979.
7. Keohler, P. R. and Moss, A. A.: Diagnosis of intra-abdominal and pelvis abscesses by computerized tomography. JAMA 244:49-52, 1980.
8. Daffner, R. H. and Halber, M.D.: Pitfall in the CT diagnosis of abdominal abscess — the full stomach. Comput. Tomography 3:33-36, 1979.
9. Masters, S. J. and Rice, R. P.: The homogeneous density of gas in the diagnosis of intra-abdominal abscess. Surg. Gynecol. Obstet. 139:370-374, 1974.
10. Wittenberg, J., Fineberg, H. V. and Ferrucci, J. T.: Clinical efficacy of computed body tomography, II. AJR 134:1111-1120, 1980.

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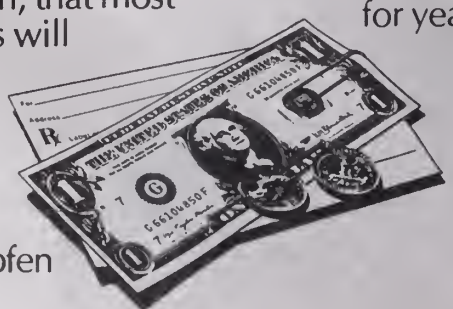
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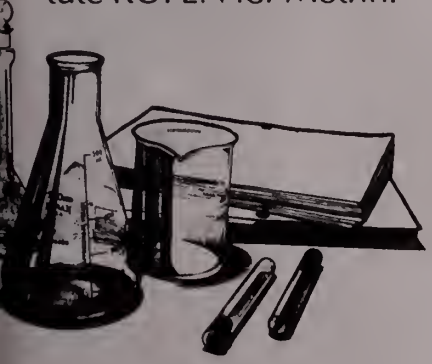
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*Incidence 3% to 9%.

Incidence less then 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hemetologic:** leukopenia, decreased hemoglobin and hematocrit. **Cerdiovescular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Ceusal relationship unknown

Gastrointestinel: Hepatitis, jaundice, abnormal liver function. **Centrel Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renel:** decreased creatinine clearance, polyuria, azotemia.

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Evaluation of the Adolescent for Scoliosis After Positive School Screening

J. PATRICK BARRETT, M.D. and MARY ALICE LEE, M.D.
Jackson, Mississippi

SCOLIOSIS IS A LATERAL CURVATURE of the spine. In the antero-posterior view of the spine on x-ray, there should be no curvature whatsoever. Any curve that is present is diagnosed as scoliosis. Long term followup studies have proven that scoliosis of a severe magnitude can cause altered regional lung perfusion and cor pulmonale, leading to premature death.[1, 2] Lesser degrees of scoliosis can cause back pain problems in adult individuals.[1, 2]

The natural history of idiopathic scoliosis has been accurately delineated only in the last 15 years.[1, 2] Approximately 80% of all scoliosis is classified as idiopathic. It is felt that there is an underlying genetic basis for scoliosis. Family history in most scoliosis patients is positive if scrutinized carefully.[3] The exact mechanism of progression of the curvature is not fully understood.

Girls are affected approximately five times more frequently than boys.[4] The age at risk is during the adolescent growth spurt which begins at approximately ten for girls and approximately eleven for boys.

From statistics gathered in the United States, it is known that for every 1,000 school-age children, approximately 100 will have a scoliosis that can be detected on a school screening examination.[5] Of this 100, approximately three will develop progression of the curve which will eventually require treatment.

If treatment is instituted early in the course of progression, a brace can be utilized to halt this progression. If treatment is delayed for an undue period of time, a surgical procedure must be utilized. The standard surgical procedure at this time is the posterior spine fusion with Harrington rod instrumentation. The Harrington instruments were perfected by Dr. Paul Harrington of Houston, Texas, approximately 20 years ago.[6] Newer instrumentations such as the Luque rod technique are, at present, still in the experimental stage.

Empirical data has led to the conclusion that curves picked up before the age of ten years will not become progressive until the child reaches the adolescent growth spurt. The detection of a scoliosis curve in its early stages can be accomplished by any primary care physician by careful physical examination. A curve of 20 degrees or less is quite often clinically unnoticeable in the erect position. If the child is allowed to bend forward with the upper extremities relaxed and suspended, the "forward bend test," then a minor rib prominence can be detected. This rib prominence is the first sign of an early scoliosis (see Figures 1 and 2).

The early detection of scoliosis is important for the non-surgical treatment of this entity. Curves from 0 to 20 degrees measured by the Cobb method need no treatment. Curves of a magnitude from 20 to 40 degrees which have proven themselves to be progressive can be treated with an orthosis (see Figure 4). The orthotic devices only prevent further progression. They have not proven to result in lasting correction of existing curves. Curves beyond 40 degrees of magnitude have proven to be quite symptomatic in adult life, and therefore, surgical correction is warranted in these cases.

If scoliosis is detected on physical examination, this should be further evaluated with a standing postero-anterior view of the spine. It is of utmost importance to obtain this x-ray in the erect position so that the factor of gravity can be properly evaluated.

Throughout our state, numerous school screening programs for spinal deformities have been initiated in the last two to three years. These screening programs will identify minor scoliosis curves. Students with positive findings are referred to their family physicians. With the "forward bend test" plus a

Dr. Barrett is engaged in the practice of pediatric orthopedics and spine deformities. Dr. Lee is District Five Health Officer, Mississippi State Board of Health.

standing x-ray of the spine measured by the Cobb method[7] (see Figure 3), a family physician can accurately evaluate a scoliosis curve.

In the Hinds County area in 1980, 2554 out of approximately 8500 junior high school students were evaluated utilizing public health nurses, Health Department personnel and physician volunteers. Two hundred and fifty-three of these students were positively identified as having spinal asymmetry by nurse screeners. One hundred and twenty of these individuals were referred to their family physicians for further evaluation after secondary screening by a physician. Of those who were further evaluated, two individuals required surgery and approximately eight individuals required brace treatment or are being closely followed for proof of progression prior to brace treatment.

In 1981 the Hinds County and Jackson public schools were screened. Sixty-eight hundred and eighty (6880) students were screened in the seventh, eighth, and ninth grades out of a total enrollment of 8844. Secondary screening by public health nurses was carried out on 604 students. Of this number, 227 were referred to their family physicians for further evaluation. These statistics are felt to be in line with national statistics.

This Health Department program is being expanded to the ten-county area of Public Health District Five in central Mississippi for the 1981-1982 school year.

The success of screening programs depends on the accurate evaluation of scoliosis by the primary care physician and early referral for appropriate orthopedic care in patients with progressive curves.

Summary

As school screening for scoliosis becomes prevalent in our state, more students with positive screening findings are referred to their family or primary care physicians. With the aid of the "forward bend



Figure 1. "Moderate" scoliosis curve viewed in erect position.



Figure 2. "Forward bend test" in same patient. Note rib hump on right showing obvious scoliosis.

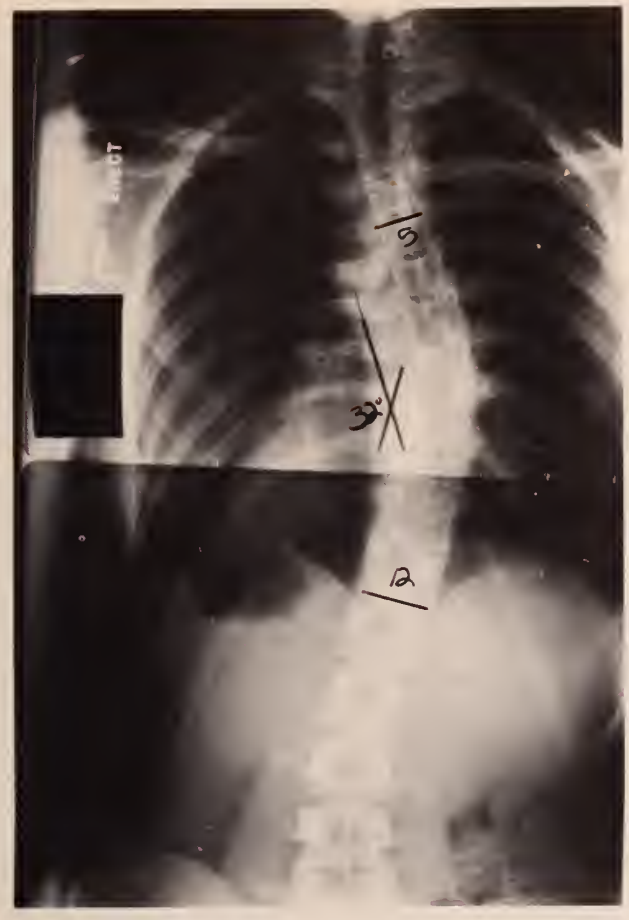


Figure 3. X-ray of same patient measured by method of Cobb.



Figure 4. Modern "low profile" orthosis for conservative treatment of scoliosis.

test" and an erect postero-anterior x-ray of the thoraco-lumbar spine properly measured by Cobb's method, these students can be properly evaluated and referred for orthopedic care early in the course of progression, thus preventing possible surgery in later life. ★★★

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Bibliography

1. Nachemson, A.: A long term followup study of non treated scoliosis. Acta Orthop. Scand. 39:466-476, 1968.
2. Nilsonne, U. and Lundgren, K. D.: Long-term prognosis in idiopathic scoliosis. Acta Orthop. Scand. 39:456, 1968.
3. Wynne-Davies, Ruth: Familial (idiopathic) scoliosis. A family survey. J. Bone and Joint Surg. 50-B:24-30, Feb. 1968.
4. Kane, W. J. and Moe, J. H.: A scoliosis-prevalence survey in Minnesota. Clin. Orthop. 69:216-218, 1970.
5. Brooks, H. L., Azen, S. P., Gerberg, E., Brooks, R. and Chan, L.: Scoliosis: A prospective epidemiologic study. J. Bone Joint Surg. 57A:968-972, 1975.
6. Harrington, P. R.: Treatment of scoliosis. J. Bone Joint Surg. 591, 1962.
7. Cobb, J. R.: Outline for the study of scoliosis. A.A.O.S. Instructional Course Lectures 5:261, 1948.

The Stimulated Granulocyte as an Effector of Immune Injury Or, The Fickle Phagocyte: Friend or Foe?

DALE E. HAMMERSCHMIDT, M.D.
Minneapolis, Minnesota

SINCE THE LATTER PART of the 19th century, a role has been postulated for the activated granulocyte in immune tissue injury. Though Metchnikoff first proposed the concept in 1887, it is in the most recent few decades that enough has been learned of granulocyte function to start to understand just how those cells — normally our good friends — can also do us harm.

"Frustrated Phagocytosis"

The most familiar model of granulocyte-mediated tissue injury is the "frustrated phagocytosis" model proposed by Henson. This is the sort of damage that often occurs in immune arthritis or glomerulitis, and is schematically presented in Figure 1. Immunoproteins are deposited upon a basement membrane, either as antibodies directed against that basement membrane or as immune complexes which are deposited passively. This deposition may result in activation of the complement system, which then produces vasoactive anaphylatoxins (C3a, C4a, C5a), a major opsonin (C3b), and a major chemotaxin (C5a). So local vascular permeability is enhanced and phagocytes are recruited to the scene, where they encounter a basement membrane which looks great to eat!

The result is predictable: the granulocyte tries to eat the delectable basement membrane, but cannot do so because it is enormous in comparison with the PMN; as the polymorph attempts to form a phagocytic vacoule to encompass the target, proteolytic enzymes and toxic oxygen compounds — weapons normally used to wage war against engulfed microbes — spill out into the inflammatory exudate, where they can do damage both directly and by activating other biologic systems (kinins, coagulation, fibrinolysis).

Intravascular PMN Behavior as a Disease Mechanism

In addition to this mechanism, our group at the University of Minnesota has had a particular interest in the concept that the *intravascular* behavior of the PMN might be pathophysiologically important as well as its behavior in inflammatory exudates. Our interest was initially provoked by the observation that the PMN count in the peripheral blood drops to nearly zero early during hemodialysis using cellophane membrane apparatus. While the count was low — and for a time thereafter — there were mild but easily demonstrable changes in pulmonary function. A series of observations by Drs. Philip Craddock and Jorg Fehr led to the inference that the plasma complement system was activated via the alternative pathway when blood came in contact with the cellophane membrane of the dialyzer; this complement activation then led to sequestration of PMNs in the lung, with attendant mild respiratory dysfunction.

PMN Aggregation

The mechanism whereby PMNs might become sequestered in the lung then became the object of study by Dr. Craddock and myself. There seemed to be at least three reasonable hypotheses: (a) the activation of complement might make the PMNs non-specifically sticky, so that they lodged in the first microvascular bed they encountered; in hemodialysis, this would of course be in the lung; (b) the activation of complement might make endothelium non-specifically sticky, with the same end result; (c) (less likely but more interesting) PMNs might share

An essay based upon a lecture read before the 113th Annual Session, April 29, 1981, Biloxi, MS.
From the Department of Medicine, University of Minnesota Medical School, Minneapolis, MN.

with platelets the ability to aggregate in response to certain stimuli; complement activation might then be one such stimulus, and the cells might then go to the lung as tiny emboli. To test this latter hypothesis, we purified PMNs from normal human venous blood, and placed them in an aggregometer of the type which is used to study platelet function. When activated complement was added (as zymosan-incubated normal human plasma), a wave of increasing light transmission was seen, quite reminiscent of a platelet aggregation wave (see Figure 2). This was shown in fact to be aggregation by examining specimens fixed at the peak of the waves; as shown in Figure 2, the PMNs were seen to be present in clumps rather than dispersed as singlets. A series of studies not depicted then identified the active complement fragment C5a (or its desarginine derivative) as the PMN aggregating substance.

We were excited by this observation, because it gave us a new pathophysiologic hypothesis for study: PMNs might do damage by aggregating and then embolizing to microvascular sites. Further, the aggregation response was predictable, allowing PMN aggregometry to be used as a simpler assay for C5a than those which had existed before; it proved an exquisitely sensitive way to detect complement activation, much as fibrin degradation products may be sought as a very sensitive way to detect activation of the clotting system.

Granulocyte-Mediated Endothelial Damage

Also within our department, several workers in the laboratory of Dr. Charles Moldow became interested in the pulmonary dysfunction and pulmonary edema which had been seen in earlier dialysis studies. They postulated that the stimulated granulocyte might be able to injure endothelium, and began growing human endothelial cells in tissue culture; when these cells were labeled with radiochromium, release of radioactivity could then be measured as an index of cell damage.

Endotoxin was added to such cultures; despite the textbook wisdom that endotoxin does nasty things to endothelium, no increase in chromium release was noted. But endotoxins are known to stimulate PMNs; when PMNs were added to the system, a modest but significant increase in chromium release occurred. Many endotoxins are also known to activate plasma complement; when a source of activatable complement was also present, the endothelial damage became striking. This damage was largely inhibited by superoxide dismutase and catalase — enzymes which detoxify reactive oxygen compounds — suggesting that most of the damage was

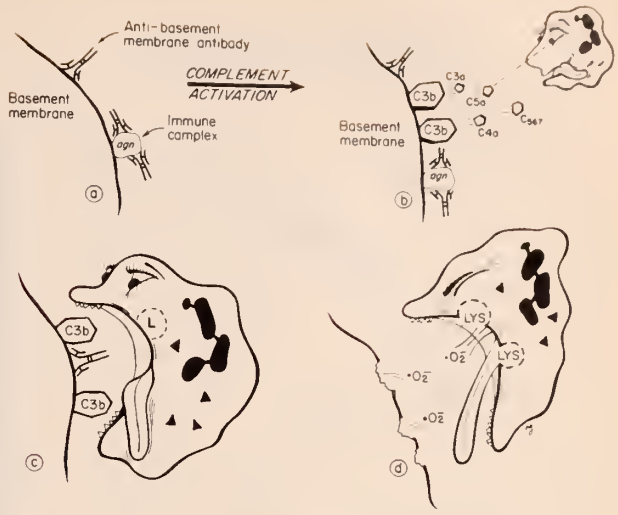


Figure 1. The "Frustrated Phagocytosis" model of immune tissue injury. When antibody attaches to a basement membrane, or when immune complexes are deposited on a basement membrane (panel a), complement may be activated. When this occurs, several biologically active "split-products" are released: the vasoactive anaphylatoxins (C3a, C4a, C5a) increase local vessel permeability; the major chemotaxin, C5a, recruits granulocytes to the scene; the major opsonin, C3b (the part of C3 remaining on the membrane), makes the membrane look tasty to a phagocyte (panel b). Predictably, the phagocyte makes an attempt to eat the basement membrane (panel c). Since the tissue bearing the membrane is far larger than the phagocyte, this is of course impossible. In the attempt to engulf the tissue, the phagocyte releases the toxic oxygen compounds ($.O_2-$) and lysosomal enzymes (LYS) that it would usually use to kill bacteria; but instead of being released into a microbe-containing phagosome, they are released into the milieu, resulting in damage to the basement membrane and adjacent structures. Anthropomorphically, this may be perceived as the poor PMN's trying and trying to engulf the enormous basement membrane, until she finally vomits!

wrought by the stimulated PMNs' production of oxygen radicals. Other laboratories have also noted that some of the proteases released from stimulated granulocytes are capable of delaminating endothelial cells from their substrate, another possible way to make the microvasculature leak. Finally, although this review centers upon the PMN, the platelet should not be forgotten: when platelets are added to the endothelial culture system along with PMNs, a further substantial increment in endothelial damage accrues.

ARDS, or the "Shock Lung" Syndrome

The stasis of PMNs in the lung when complement was activated was reminiscent of that which occurs in experimental models of shock. Further, animals

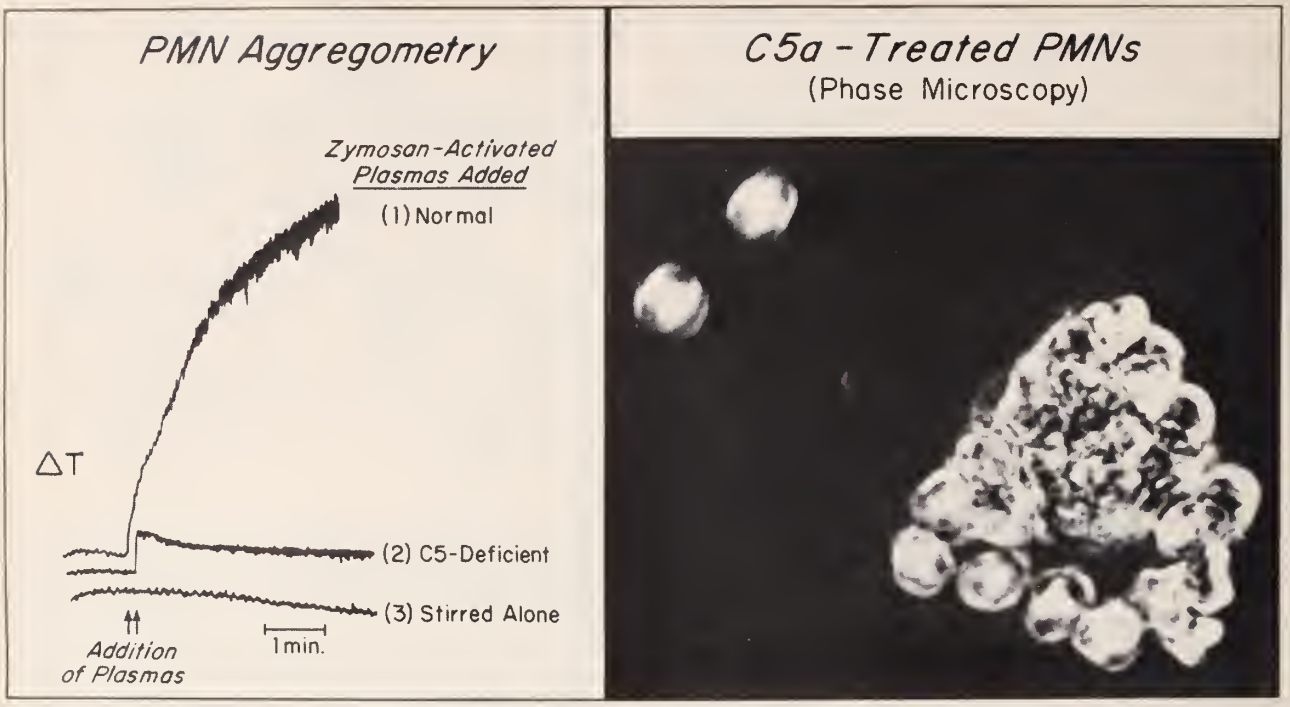


Figure 2. The granulocyte shares with the platelet the ability to aggregate in response to certain stimuli, including activated complement. When purified normal granulocytes are placed in an aggregometer, and activated plasma complement is added, a wave of increasing light transmission occurs, reminiscent of a platelet aggregation wave (left panel). This wave can be shown in fact to represent aggregation by fixing samples at the peak of the wave, then examining them microscopically (right panel). This aggregating activity has been shown to be due to the presence of C5a or its desarginine derivative; one piece of evidence is that the activity cannot be generated in plasma from a patient with a severe congenital deficiency of C5 (left panel). In other studies not shown, such aggregation has been shown to occur in vivo, *and such stimulated PMNs have been shown to damage endothelium. We propose therefore that the intravascular behavior of the stimulated neutrophil may be pathophysiologically important.*

which had been depleted of granulocytes or of activatable complement had been reported to be resistant to irreversible shock and to some shock-associated pulmonary abnormalities. And finally, the "shock lung" syndrome most frequently occurs in clinical contexts characterized by complement activation: trauma, sepsis, acute pancreatitis. These parallels led us to postulate that the complement-stimulated granulocyte might play some role — perhaps as a trigger or amplifier — in the genesis of ARDS (Adult Respiratory Distress Syndrome). If this guess were correct, we might hope to find some reflection of the process in patients with ARDS. In a pilot study, plasmas from patients with ARDS were tested as aggregants of normal granulocytes; in 26 of 30 patients, the plasmas *did* aggregate normal PMNs, and the activity could be traced to the presence of abnormal amounts of C5a.

Encouraged, we entered into a somewhat more rigorous study, in which samples were obtained from a large number of injured patients at risk for ARDS, and were tested for C5a without knowledge of the clinical status of the patients. When the code was broken, a strong and highly statistically significant association was found between the presence of abnormal amounts of C5a and the ultimate development of "shock lung"; in a small cohort of patients studied at very frequent intervals, the C5a level often became abnormal 12 or more hours before hypoxemia developed, allowing us to hope that the detection of complement split products might be a tool for predicting which traumatized patients will get ARDS, so that therapy might begin very early.

Pharmacology of Granulocyte Aggregation

Several workers have advocated the use of high doses of corticosteroids in shock and ARDS. We therefore became interested in the effects of these agents upon granulocyte aggregometry; if our hypothesis was right, and if the steroid advocates were right, one might reasonably expect to find an effect of steroids upon PMN aggregation. Such was

indeed the case.

When a constant aggregating stimulus was applied (see Figure 3) and the amount of steroid in the incubation was varied, a dose-response family of aggregation waves was produced. Little or no inhibition of aggregation resulted from the presence of 100 μg methylprednisolone per ml, an amount equivalent to at least the plasma levels in patients taking 100 mg prednisone daily. However, inhibition was seen with larger concentrations, 50% inhibition being noted at 0.6 mg/ml; this latter concentration is well within the plasma levels obtained with the very large (30+ mg/kg) i.v. bolus doses of this agent which have been advocated in shock and shock lung.

More recently, we have studied the effects of a wide variety of drugs upon granulocyte aggregation, and have found several other agents (including ibuprofen and betahistime) which also inhibit. Further, we have preliminarily reported that synergy exists among some of these agents, which may ultimately allow the benefit of steroids to be realized with only a tenth the currently-advocated dose.

Granulocyte Aggregation in Vivo

Because this pathophysiologic speculation was based upon *in vitro* observations and upon indirect observations *in vivo,* we sought to demonstrate that granulocyte aggregation and PMN-mediated endothelial damage were in fact capable of occurrence in live animals. For this, we entered into a collaboration with Drs. P. D. Harris (University of Missouri, Columbia) and H. Wayland (California Institute Technology), who are microvascular physiologists skilled in the techniques of intravital microscopy. Using techniques and apparatus which they developed, we were able to prepare rats who harbored fluorescent granulocytes or fluorescent plasma, then infuse activated complement (or complement activators) while observing a capillary bed by fluorescence microscopy.

In the former instance, fluorescent PMNs were seen immediately to marginate in the vessels, sometimes piling up so densely as to disrupt regional blood flow. After a few minutes, large clumps of PMNs were seen to form, and to embolize to smaller vessels downstream. When the plasma was rendered fluorescent and a slow constant infusion of activated plasma was given, leakage of fluorescent albumin was seen within twenty minutes as halos around true capillaries. The margination of fluorescent PMNs was blunted, and the formation of clumps and leak were completely avoided, by pretreating the rats with high doses of methylprednisolone.

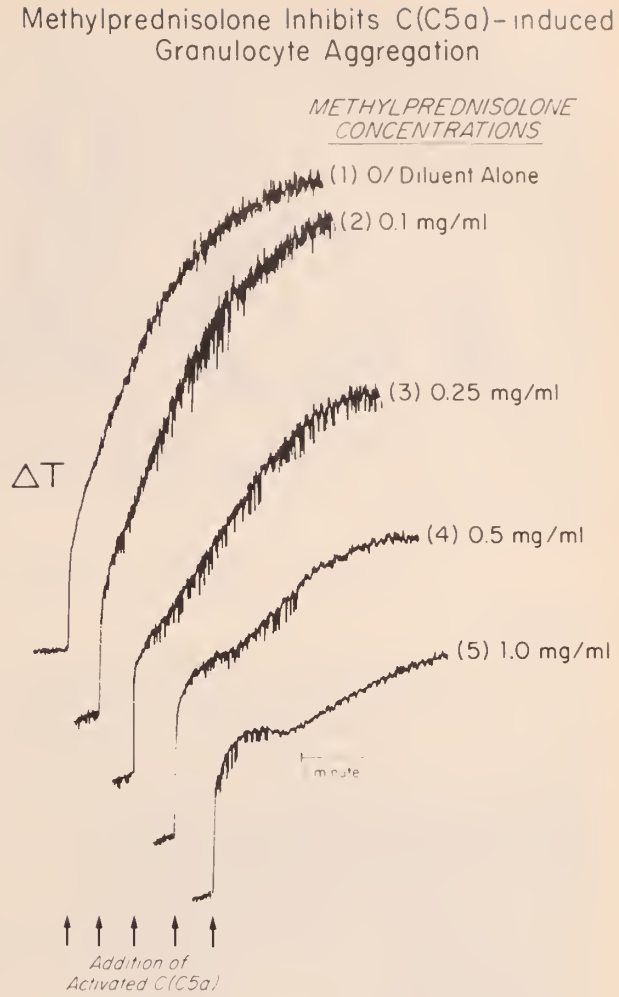


Figure 3. Corticosteroids inhibit granulocyte aggregation. When a constant aggregating stimulus is applied to granulocytes which are exposed to various concentrations of methylprednisolone, dose-dependent inhibition of aggregation is observed. 100 μg methylprednisolone per ml (the second tracing) was not different from control (top tracing), even though this would be a high plasma concentration in a patient on daily oral therapy. Higher concentrations, however, did inhibit (lower three tracings), with 50% inhibition being observed at 0.6 mg/ml (between the lowest two tracings). This concentration is in the range achieved with the very large bolus doses of steroids which have been advocated in shock and the "shock lung syndrome," encouraging our speculation that in-vitro *study of PMN response might provide useful models for developing new pharmacologic strategies to avoid the complications of shock.*

Protection of the Host

"All well and good," you might say, "but if this is an important pathophysiologic mechanism, why don't I turn to a leukostatic plug from head to foot

each time I activate a little complement with a *Strep* throat?'' The answer is twofold. First, the complement system is a very tightly regulated system, with inhibitors and inactivators at many steps. Thus, it takes quite a potent stimulus to complement activation to produce a high level of C5a — or any other active product — in the circulation. Second, even when such a potent stimulus is brought to bear, the active components are cleared from the circulation very, very rapidly. As an example, we have recently reported that the half-life of C5a activity in the circulation is only about three minutes! We are very interested in the possibility that disorders of regulation or of clearance might in some way determine just which traumatized patients go on to develop pulmonary dysfunction, and which ones make uneventful recoveries.

Conclusion

While the behavior of the stimulated phagocyte in inflammatory fluids has been thought for almost a century to contribute to tissue damage, we have only recently come to an understanding of some of the mechanisms whereby it may do so. Further, the last decade has seen the accumulation of evidence suggesting that the intravascular behavior of the stimulated granulocyte may be of pathophysiologic import, as well. Thus, the activated PMN can aggregate, embolize to microvascular sites, adhere to endothelium and damage that endothelium by releasing proteolytic enzymes and toxic oxygen compounds normally used to kill invading microbes. Activated granulocytes are being incriminated in an ever-broadening range of disease, including our laboratory's special interests, hemodialysis neutropenia and the ''shock lung'' syndrome. The behavior of the stimulated granulocyte is liable to pharmacologic manipulation, and we hope that its *in vitro* study will lead to refinements that will ultimately bear clinical fruit. ★★★

420 Delaware Street S.E. (55455)

Acknowledgements

I emphasize that the work here summarized is not all work which I have personally performed, but represents the efforts of a sizable team of investigators assisted by several fruitful collaborations. Special mention is due: Philip R. Craddock, M.B., B.S.; Jorg Fehr, M.D.; Timothy K. Bowers, M.D.; Daniel J. Weisdorf, M.D.; Patrick J. Flynn, M.D.; Gregory M. Vercellotti, M.D.; Osamu Yamada, M.D.; Thomas Sacks, M.D.; Marc Boogaerts, M.D.; Leonard D. Hudson, M.D.; Harry S. Jacob, M.D.; Carol J. Lammi-Keefe, Ph.D.; Joseph O'Flaherty, M.D.; Patrick D. Harris, Ph.D.; Harold Wayland, Ph.D.; Agustin Dalmasso, M.D.; Richard S. Kronenberg, M.D.; Charles F. Moldow, M.D.; Keith Skubitz, M.D.; L. Jean Weaver, M.D.; Patricia A. Coppo, M.S.; James G. White, M.D.

Also, the work here summarized has taken place in several laboratories over several years; it was therefore supported by a number of grants, including the following: N.I.H. (U.S.A.): AM15317, AM15730, CA08832, CA11996, CA12607, CA13722, CA15627, GM24990, HL00479, HL06314, HL06316, HL07062, HL11880, HL15215, HL16833, HL19725, HL20695, HL26218, HL25043, HL70356, as well as grants from The Veterans Administration, The Variety Club of the Northwest, The Upjohn Company, The American National Red Cross and the Minnesota Lung Association.

Key References

1. Weissmann, G., Smolen, J. E. and Korchak, H. M.: Release of inflammatory mediators from stimulated neutrophils. New Engl. J. Med. 303:27-34, 1980.
2. Ruddy, S., Gigli, I. and Austen, K. F.: The complement system of man. New Engl. J. Med. 287:489-495, 545-549, 592-596 and 642-646, 1972.
3. Craddock, P.R., Fehr, J., Brigham, K. L., Kronenberg, R. S. and Jacob, H. S.: Complement and leukocyte-mediated pulmonary dysfunction in hemodialysis. New Engl. J. Med. 296:769-774, 1977.
4. Jacob, H. S., Craddock, P. R., Hammerschmidt, D. E. and Moldow, C. F.: Complement-induced granulocyte aggregation: an unsuspected mechanism of disease. New Engl. J. Med. (Beth Israel Seminar) 302-789-794, 1980.
5. Craddock, P. R., Hammerschmidt, D. E., Moldow, C. F., Yamada, O. and Jacob, H. S.: Granulocyte aggregation as a manifestation of membrane interactions with complement: possible role in leukocyte margination, microvascular occlusion and endothelial damage. Sem. Haematol. 16:140-147, 1979.
6. Hammerschmidt, D. E., Bowers, T. K., Lammi-Keefe, C. J., Jacob, H. S. and Craddock, P. R.: Granulocyte aggregometry: a sensitive technique for the detection of C5a and complement activation. Blood 55:898-902, 1980.
7. Sacks, T., Moldow, C. F., Craddock, P. R., Bowers, T. K. and Jacob, H. S.: Oxygen radicals mediate endothelial damage by complement-stimulated granulocytes. J. Clin. Invest. 61:1161-1167, 1978.
8. Hammerschmidt, D. E., Harris, P. D., Wayland, H., Craddock, P. R. and Jacob, H. S.: Complement-induced granulocyte aggregation *in vivo*. Amer. J. Pathol. 102:146-150, 1981.
9. Hammerschmidt, D. E., White, J. G., Craddock, P. R., and Jacob, H. S.: Corticosteroids inhibit complement-mediated granulocyte aggregation: a possible mechanism for their efficacy in shock states. J. Clin. Invest. 63:798-803, 1979.
10. Hammerschmidt, D. E., Weaver, L. J., Hudson, L. D., Craddock, P. R. and Jacob, H. S.: Association of complement activation and elevated plasma-C5a with adult respiratory distress syndrome: pathophysiologic relevance and possible prognostic value. Lancet i:947-949, 1980.

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The President Speaking

Reaching Goals Through Political Action

R. FASER TRIPLETT
Jackson, Mississippi

Doctors Paul Moore, Ed Hill, our executive secretary Charlie Mathews and I had a very amicable but frank discussion and, I hope, productive meeting with representatives of HHF in Washington on September 17. We presented our case for a single area designation for Medicare payment purposes in Mississippi.

Representative Trent Lott arranged our meeting, and we were treated very cordially and allowed ample time for our presentation. We were encouraged to the extent that we were not told flatly that it couldn't be done and that there was possibly a method available to accomplish our goal. However, they did require additional fiscal data and had to make certain legal searches before giving us a final answer. We were assured by the Deputy Administrator for HHF who was present at the meeting that our request would be given thorough consideration. The MSMA staff intends to see that this is done and will keep you informed of the results. The problem of equal Medicare payments in all areas of the U.S. was approached briefly but we are all aware that this can only be accomplished by congressional action and the mood on Capitol Hill at the present time gives us little hope for action. The AMA lobby continues to press Congress however, for an end to the economic index.

While in Washington we joined Jimmy Manning, MMPAC board chairman, Stanley Hartness, MMPAC board member, and Bucky Murphy, MSMA assistant executive secretary, in participation in an AMPAC political education conference held in conjunction with AMPAC's 20th birthday. The meeting included workshops on such topics as recruiting candidates, increasing membership, organizing campaigns, and fund raising and volunteer recruitment on conducting voter registration drives. Regardless of your political affiliation, you should be pleased to know that AMPAC is given a great deal of credit by the "powers that be" for achieving the present conservative makeup of both the Administration and Congress. If the President's economic program is successful, as we all hope and pray it will be, we can justifiably claim some of the credit.

Recent AMA surveys show that 65% of all physicians agree that the medical profession should support political representative action undertaken by the profession, but unfortunately the high percentages that show strong support for AMPAC are not reflected in AMPAC membership. It is our goal this year to see that Mississippi leads the way for the rest of the nation in support for AMPAC both in percent of membership by MSMA members and in per capita giving. We ask you to do your share to help your medical association reach this goal. Only then can we continue to lay the groundwork for solid political support for the positions that we feel are essential in order for us to provide quality care to our patients in a free enterprise atmosphere. ★★★

EDITORIALS

JOURNAL OF THE
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VOLUME XXII, Number 11

NOVEMBER 1981

Hazards of Small Recreational Vehicles

An editorial in the *Journal of the Mississippi State Medical Association,* Volume 21, No. 5, May 1980, addressed the problem of an increasing number of injuries associated with increased use of small recreational vehicles, three wheel cycles, go-carts, trail bikes, etc. Since that editorial there has been a marked increase in the number of three wheel cycles sold to the public. Paralleling this rise in availability and usage has been a marked increase in the number and seriousness of injuries associated with the use of such vehicles.

Almost every day advertisements by the major producers of such machines can be seen on television. These all depict racing, stunt driving and other very dangerous uses of these machines. Such advertisement only entices the public, particularly the younger people, to attempt such stunts and daring feats when they are ill prepared and in no way trained to do so. Over the past four months some 40 patients with serious injuries and three deaths have been seen from three wheel accidents in the Jackson area. Because of this serious rise in the number of injuries associated with this activity, the Central Medical Society Executive Committee recently voted to make a public statement to the press regarding the dangers associated with the use of such vehicles and to petition the local police department and the Mississippi Highway Safety Patrol to strictly enforce all laws regarding the use of these vehicles on public streets and highways.

This editorial is not intended as a simple repeat of the earlier editorial. This has now become a major public health hazard and cannot be ignored. As stated earlier, all physicians should become involved by advising their patients of the hazards associated with these machines, encouraging proper usage, and assisting local groups in developing safety programs or campaigns promoting proper use of small recreational vehicles.

MYRON W. LOCKEY, M.D.
Associate Editor

JOIN MPAC TODAY

GUEST EDITORIAL

A Patient's View

Editorial Note: Jimmy Ward, editor of the *Jackson Daily News* and longtime friend of the association, recently wrote about his personal experiences with modern medicine. We thought JOURNAL MSMA readers would enjoy his comments. — C.L.M.

Unfortunately I have not been a participant in this space for a couple of weeks. The reason: I've been on a journey, a medical journey. You might say I've been on a trip, the sort of trip that could be compared to an adventure in a time capsule.

Fortunately this old trooper is back at the cluttered desk he loves so well.

My trip began routinely enough with admission to the Mississippi Baptist Medical Center, where needles give and needles take away — especially vials of blood that go to the chemists who discover a great deal about your body.

Enter the time capsule. The hospital has some 21st Century equipment — CAT scanners that photograph, trace and track mysterious isotopes that bounce back and forth in the bones or organs where they have been directed to dance.

There are other space age machines. A skilled technician gives vivid instructions. You perform, a computer keeps score. If you make a miscue or fail

to follow instructions, the computer says "tilt" and you repeat the test.

Then there's a printed summary of your performance. It says that even an airplane with just one engine can fly the planned mission.

Then you enter another period of timelessness. You are put to sleep by what must be called miracle drugs compared with a few years ago in the medical profession.

Skilled surgeons, whom you have known from previous experiences, are at work; but you know nothing of what they are doing. You are eons away yourself, as if on some Orbiting Planet Country where no one knows anything about the Space Age.

In the intensive care unit you pass into another time zone. Unable to speak due to tubes and things, you signal for a pad and pen. You hope to write a message. This is known as the Age of Hieroglyphics in your trip in time. Your mind knows what it wants to communicate. Your fingers yield squares, circles, a "t" with two or three crosses at the top and bottom. It's a piece of art you later learn would make an Egyptian mummy jealous of your literary genius; but it makes no sense to the nurse or your anxious family, probably causing them to wonder if you will return to the 20th Century from the Prehistoric.

Upon being assigned to a comfortable room and still unable to speak, you enter the age of the Indian Sign Language. You discover to the delight of yourself and the nurse that you can specifically identify which cold, metal utensil you need under your body at a critical moment. Time Marches On!

Meal time is another experience in this time capsule. Still unable to speak or swallow, your meal comes trickling down from a glass container down a transparent tube. You watch with non-hungry interest. The fun-minded nurse asks, "How does it taste?" She knows and I know that the nourishment is bypassing all your taste buds and is going directly into your system.

You enter another era in this adventure. You discover you can read and write again. You're in the Pad and Pencil Era, having graduated from the mummified Age of Hieroglyphics. You let visitors do the talking and you respond by scribbling notes. Brother, that's past kindergarten, wouldn't you say?

Not to mix medicine with the automobile business, but out come the tubes and you are riding on radials. You've entered the Industrial Revolution.

You are alert enough now to tell every person you see or hear how grateful you are — for the doctors, nurses, technicians, family, friends, professional associates, readers, and even strangers who say they've said their share of prayers, too.

You are going home tomorrow — a risky time, you are told. Because of the euphoria, you may try to do some things which your lack of strength won't permit. The Age of Gradualism.

Speaking of gradualism, you become aware again that the 20th Century is still here. That President Reagan has a few pains himself — with a budget, with a tax and with the AWACS.

Even with all of this personal, domestic and international awareness there is a wonderful bottom line. On this trip you realize, gratefully, that you were issued a Providential Round Trip Ticket.

Thanks, everybody. It's good to be back!

(Reprinted from the October 5, 1981 issue of the Jackson *(Miss.)* Daily News.*)*

LETTERS

To The Managing Editor: A. Guess whose publication had a difference in the table of contents from title of article?

B. Guess who waited a long time to comment — and finally decided, "what the heck?" and is now doing so?

Yours,
Dr. A.

Editorial Note: We assume the reader is referring to the inadvertent substitution of the word "fault" for the word "problem" in the table of contents listing for the article entitled "Impotence — Whose Problem Was It?" The article appeared in the September issue of Journal MSMA.

Although it is a policy not to publish unsigned letters to the editor, the anonymous message above, which was marked "confidential," is printed to illustrate a problem which often plagues writers and editors — a reluctance on the part of readers to make comments.

Lack of feedback has tempted many editors to deliberately print an error (and some have been known to do so) in order to see "if anyone out there is reading." While we might like to make that excuse in this instance, the fact is that it was, indeed, a mistake. And as such, it distresses and embarrasses no one more than it does a person who is engaged in the business of words, particularly a business which demands accurate words. We do regret the error.

We also apologize for the switching of cutlines and misprinting of two illustrations in that article. Three proofreaders failed to catch that mistake before final printing. That issue had more than its share of "problems," and the "fault" was ours. — P.W.S.

1982 MSMA-Robins Award Is Announced

The twenty-first annual Mississippi State Medical Association-Robins Award or outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1982 award will be presented at the 114th Annual Session.

Each component society has been invited to submit a nomination for the honor. Deadline for submission of nominations to the state medical association headquarters is Jan. 2, 1982. Each nomination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

Nominees must be members of the state medical association, and the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural or economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be re-submitted.

The Robins award is sponsored annually by the association and the A. H. Robins Company of Richmond, VA. The series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 20 Mississippi physicians who have received the high honor are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965;

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by Delta Medical in 1967; Dr. W. H. Anderson of Booneville by Northeast in 1968; Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969; Dr. W. J. Aycock of Calhoun City, by the Northeast Society in 1970; Dr. Walter H. Rose of Indianola, by Delta Medical Society in 1971; Dr. Reginald P. White of Meridian, by the East Mississippi Medical Society in 1972; Dr. W. A. Long, Jr., of Jackson, by the Central Medical Society in 1973; Dr. Virginia S. Tolbert of Ruleville, by Delta Medical Society in 1974; Dr. Thomas M. Davis of Jackson, by Central Medical Society in 1975; Dr. Thomas G. Barnes of Greenville, by Delta Medical Society in 1976; Dr. Hugh Banks Barnes of Hattiesburg, by South Mississippi Medical Society in 1977;

Dr. Verner S. Holmes of McComb, by South Central in 1978; Dr. W. L. Jaquith of Whitfield, by Central Medical Society in 1979; Dr. Jack Atkinson of Brookhaven, by South Central in 1980; and Dr. W. Lamar Weems of Jackson, by Central Medical Society in 1981.

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114th Annual Session

Mississippi State Medical Association

May 2-6, 1982
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Jackson, MS 39216



Elise Winter, wife of Governor William Winter, was among those who spoke at the opening of the Alcohol and Drug Center at Doctor's Hospital in Jackson recently. Welcoming Mrs. Winter and other guests was hospital administrator Jimmy LeDoux, at right.



Dr. Doyle P. Smith of Jackson, left, director of the Alcohol and Drug Center of MSMA's Disabled Doctors' program, and Dr. G. Douglas Talbott of Smyrna, GA, talk briefly before making their addresses at the opening of the ADC.

MISSISSIPPI STATE MEDICAL ASSOCIATION

114th Annual Session

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MAY 2-6, 1982

A COMPLETE MEETING

- 14 Scientific Sections
- Specialty Society Meetings
- Scientific Exhibits
- Alumni Reunions
- Auxiliary Activities
- House of Delegates
- Tennis, Golf, Fishing and Jogging
- 125th Anniversary Party

University Medical Center Enrollment Increases

The University of Mississippi Medical Center has announced an increase in enrollment.

Enrollment in all schools and programs is 1680 this year compared to a 1980 enrollment of 1617.

Enrollment breakdown is 600 in the School of Medicine, 227 in the School of Nursing, 261 in the School of Health Related Professions, 168 in the School of Dentistry, 71 in graduate programs in the basic sciences, 296 in postgraduate training and 57 in certificate programs.

The largest increase came in the graduate program with a 16 percent increase over last year followed by the School of Nursing with a 14 percent increase in enrollment.

More Reductions Coming For Health Programs

Despite its earlier history-making budget reduction of some $30 billion, the Administration is now faced with an estimated $60 billion deficit in this fiscal year (Oct. 1, 1981) with even higher red ink margins forecast in the next two years.

In its drive to get the deficit down to $42.5 billion, the pre-August guess, some $18 billion of new cuts must be legislated. Health programs aren't a major target area, but few will escape the economy ax.

The President's urgent request for a second round of budget cuts would involve a reduction of $1 billion or more in federal health programs, already hit hard by the budget reconciliation measure approved last August.

Most of the President's proposed savings, $8.4 billion, would come from a 12 percent, across-the-board slice in appropriations for all domestic programs. The health programs at the Health and Human Services (HHS) Department currently are budgeted at about $6.5 billion, meaning they would be reduced about $780 million. Further cuts apparently would come from Medicare and Medicaid.

The President said in a nationally-televised speech that he will seek $2.6 billion in cuts from entitlement programs in the budget not subject to the appropriations process. These include Medicare and Medicaid, but how much they would be hit remains to be seen.

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Rectal Cream with Hydrocortisone Acetate
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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
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Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
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Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
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Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
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AMPAC Holds Washington Meeting

Addressing AMPAC's 20th anniversary political education conference in Washington, DC, Sen. Wendell Ford (D-KY) told 400 AMPAC members that "you people wrote the book on how to make a PAC work and without question your organization's record of success stands alone."

Describing AMPAC as "a force to be reckoned with," Sen. Ford said in prepared remarks that PACs exert a positive influence on the political process. "Keep up the good work," he said, "and remember that the bottom line is a more responsive and responsible government."

"If ever there was a time for individuals and groups to come together to help minimize the impact of the budget reductions, that time is now," he said. "The need will never be greater or more urgent because the government can no longer afford to carry out all responsibilities."

Sen. John Heinz (R-PA) said that without the help of AMPAC and similar groups the Republicans would not have been able to capture the Senate where GOP control was essential for President Reagan's legislative victories. "We will bring the budget in line; that you can depend on," the senator said.

AMPAC Board Chairman, John Smith, M.D., said the 1980s will bring sweeping changes. "We must play a major role. Our voices will be heard and our presence felt," said the San Antonio physician. Dr. Smith said AMPAC "must be ready to influence positively the decisions made. Medicine and politics do go together."

Attending the AMPAC meeting from Mississippi were: Drs. James O. Manning, Jackson; J. Edward Hill, Hollandale; Stanley A. Hartness, Kosciusko; Paul H. Moore, Pascagoula; and R. Faser Triplett, Jackson.

Health Block Grant Program Is Under Way

The Administration's health block grant program is operational, but some states may decide to delay for as long as a year.

At a series of regional conferences, Administration officials have been assuring state officials they will be allowed "maximum flexibility" in administering the programs covered under the block grants.

Edward Brandt, M.D., Assistant Secretary for

Health at the HHS Department, said his agency is "carrying out the principles of flexibility, minimum federal intrusiveness, and absolute neutrality in its implementation activities."

Dr. Brandt noted that states may choose to assume responsibility for administering the block grant programs immediately or to phase in the operation of the blocks during the fiscal year which began October 1, 1981.

Congress put some 20 Public Health Service programs into four block grants — Preventive Health; Maternal and Child Health; Mental, Drug and Alcohol; and Community Health Centers. States can administer the block grant funds with much more freedom than existed for the categorical programs.

Dr. Brandt told the Block Grant Regional Conference in Dallas this month that HHS is authorized to continue making awards to individual program grantees in states until the states assume control over the block grants. "But we will only take this action if an existing grant comes up for renewal before you (the states) take over the block containing that particular grant program."

The amount of money the states will receive for the block grants won't be known until Congress completes the appropriations process. Dr. Brandt said "the best I can tell you now is that we are going over prior years obligation figures for each program in the blocks to establish the basis for calculating your particular state's share of each block."

The law requires each state to tell how it intends to spend its block grant funds. Citizens are supposed to take part in the decision-making process at the state level, but "we will have no federal guidelines or proposed federal regulations concerning public participation."

In Mississippi, Governor Winter has appointed a committee composed of state agency directors and an advisory committee of private citizens to recommend expenditure of block grant funds. The state agency directors selected by the governor are: Dr. Alton B. Cobb, State Health Officer; Dr. Jan Dukes, Director, Department of Mental Health; Mr. Dick Molpus, Director, Governor's Office of Federal-State Programs; Mr. Jim Cofer, Director, Commission on Budget and Accounting; and Dr. Donald B. Roark, Commissioner, Department of Public Welfare.

★ ★ ★

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PD-400-JA-0146-P-1 (1-81)

Medicaid Seeks $80 Million In State Funds

The Mississippi Medicaid Commission has requested $80.4 million in state funds for a $347.4 million budget in fiscal year 1983. The request was recently made before the State Commission on Budget and Accounting, which is drafting its recommendations for the 1982 Regular Session of the Mississippi Legislature.

State Medicaid director B. F. Simmons told the Commission that an increase of $5.3 million in state funds over last year was being requested to match an increase of $21.2 million in federal funds. An estimated 305,000 persons will be covered by the program.

Simmons cautioned that the $80.4 million in total state funds could be insufficient in view of anticipated reductions in federal funding. In that event the state would have to come up with additional funding or cut benefits and payments. The deficit in federal funds could run some $4.7 million this year and some $10.6 million next fiscal year.

The Medicaid program is seeking funding for 23 additional employees to conduct a review program of nursing home services in place of a program conducted by the Mississippi Foundation for Medical Care — PSRO. Medicaid officials said the primary reason for expected increases in spending are rising costs of institutional care.

UMC Announces Faculty Appointment

Dr. Ben H. Douglas has been named assistant vice chancellor for graduate studies at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced his appointment following approval by the Board of Trustees, State Institutions of Higher Learning.

On the UMC faculty since 1964 and acting vice chancellor since 1980, Dr. Douglas also serves as professor of anatomy and associate professor of physiology and biophysics at the Medical Center. He earned the B.S. at Mississippi College and the Ph.D. at the Medical Center.

Dr. Douglas, first Mississippian to be appointed as American Heart Association established investigator, received the Mississippi affiliate's prestigious Silver Distinguished Achievement Award in 1978. He is a past chairman of the Mississippi Academy of Science's medical science division and a charter member of the Society for the Study of Reproduction.

He has served on the boards of directors for the Mississippi Acadmey of Science, the Hinds County Heart Association and the Mississippi Heart Association and on the editorial board of Clinical and Experimental Hypertension.

Dr. Douglas is a member of the American Physiological Society, the Society for Gynecologic Investigation and the International Society for the Study of Hypertension in Pregnancy. He is on the medical advisory board for the Council for High Blood Pressure Research.

Author of two books and contributing author to three more, Dr. Douglas has published some 215 scientific papers.

Congressmen Urge Legalization of Marijuana

Two congressmen want the federal government to recognize the therapeutic benefits of marijuana for cancer and glaucoma patients.

Representatives Stewart McKinney (R-CT) and Newt Gingrich (R-GA) have introduced a bill that would amend the Controlled Substances Act to recognize the medical use of marijuana, without affecting penalties for social use.

Federal law defines marijuana as a drug with no acceptable medical use, and it is available by the federal government only for research. This makes it difficult for patients in 32 states where its medical use is allowed to obtain the drug legally.

Marijuana is said to treat the adverse side effects of cancer chemotherapy and to reduce intraocular pressure in glaucoma patients.

Medico-Legal Brief

Wrongful Birth Suit Not Against Public Policy

A mother can maintain an action against a physician for the wrongful birth of a normal, healthy child two and one-half years after he performed a tubal ligation on her, a Pennsylvania appellate court ruled.

The tubal ligation was performed on June 11, 1974, and the child was born on January 2, 1977. The mother filed suit against the physician who performed the tubal ligation and the hospital where it

was performed. The action was based on breach of contract and negligence theories. A trial court held that it was against the public policy of the state to recognize claims for the birth of a child.

On appeal, the appellate court reversed the decision. Following two decisions rendered after the trial court's ruling, the appellate court said that it would recognize a cause of action for medical malpractice in which the birth of a healthy, normal child was the injury suffered. The mother's complaint alleged that the physician breached his duty to her and that his negligence caused her damages. That stated a cause of action, the court said. The mother also stated a cause of action for breach of an express warranty that the operation would result in sterility.

On the question of damages, the court said that the mother would be entitled to recover all damages that resulted from the physician's negligence or breach of contract, including expenses of rearing the child. The court said that parents of children born with deformities were not limited to damages related to the child's illness but were allowed damages for the expenses of rearing the child if it were normal and healthy. The mother of a normal, healthy child should also recover damages for rearing an unwanted child, the court said.

The jury should be permitted to reduce the amount of damages by an amount that represented the benefit that the child would bring to the mother. Damages for the mother's lost earning, physical pain and suffering could be recovered, but damages for emotional and mental distress were not recoverable, the court said.

The case was remanded to the trial court for further proceedings. — *Mason v. Western Pennsylvania Hospital,* 428 A.2d 1366 (Pa.Super.Ct., April 16, 1981)

POSTGRADUATE CALENDAR

Dec. 3, 1981
HEMATOLOGY IN THE NEONATE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine, the Department of Obstetrics and Gynecology and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the Division of Newborn Medicine, and Gwen Bussa, R.N., C.N.M., M.N., assistant professor of nursing and instructor in obstetrics and gynecology (nurse-midwifery).

This program will look at normal hematologic findings and their variations in the newborn. Registration is limited to 10. This program is made possible in part by the General Continuing Medical Education Fund of the University of Mississippi Alumni Association Guardian Society. Fee: $35. Credit: 5.5 credit hours in Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

Dec. 10-11, 1981
THIRD ANNUAL MISSISSIPPI PERINATAL POSTGRADUATE COURSE
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine; the Department of Pediatrics Division of Newborn Medicine; The School of Nursing; and the Medical Center Division of Continuing Health Professional Education. Partial support is provided by the Mississippi Perinatal Association, Mead-Johnson, Ross Laboratories and the Obstetrics and Gynecology Continuing Medical Education Fund of the University of Mississippi Alumni Association.

Coordinators: John C. Morrison, M.D., professor of obstetrics and gynecology and director of the Division of Maternal-Fetal Medicine, and Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the Division of Newborn Medicine.

This program will take a multidisciplinary look at methods of solving perinatal health care problems. Lectures and panel discussions will cover the most recent scientific developments in the field of perinatology. An outstanding guest faculty join UMC faculty members in presenting the program. Fee: $200. Credit: 12.5 credit hours in Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

Dec. 17, 1981
NEWBORN METABOLISM — FLUIDS AND ELECTROLYTES
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Di-

POSTGRAUDATE / Continued

vision of Newborn Medicine, the Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine, and School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the Division of Newborn Medicine, and Gwen Bussa, R.N., C.N.M., M.N., assistant professor of nursing and instructor in obstetrics and gynecology (nurse-midwifery).

This program, limited to 10 participants, will define the normal fluid and electrolyte status and medications in newborns, and the abnormalities that might occur and their treatment. This program is made possible, in part, by the General Continuing Medical Education Fund of the Guardian Society of the University of Mississippi Alumni Association. Fee: $35. Credit: 5.5 credit hours in Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

Jan. 16, 1982
ENDOCRINOLOGY OF THE AGING WOMAN
The Jackson Regency, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: G. William Bates, M.D., associate professor of obstetrics and gynecology.

This seminar will present current concepts of menopause and emphasize indications and contraindications for hormonal replacement therapy. The physiology of ovarian failure and pathophysiology and estrogen deficiency will be covered. Fee: $30. Credit: 3.5 credit hours in Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

Jan. 23, 1982
PHOTOGRAPHY FOR EDUCATION AND SLIDE PROGRAMS
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Dentistry and the Medical Center Division of Continuing Health Professional Education.

Coordinator: William B. Akerly, D.D.S., UMC associate professor of restorative dentistry.

This program is open to physicians, dentists, teachers and hobbyists. Sessions will focus on macro-lens and close-up photography. Films, filters and reverse-text production techniques will be covered. Methods for graphic illustration and copying, such as polarization, glass supports and background materials, also will be demonstrated as a means for making effective title or lecture slides. Fee: $50.

FUTURE CALENDAR

Feb. 4-5, 1982
RENAL UPDATE
Ramada Inn Coliseum, Jackson

March 11-13, 1982
SURGICAL FORUM IX
Holiday Inn Downtown, Jackson

For information on these and other seminars, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson 39216. Phone (601) 987-4914.

NEW MEMBERS

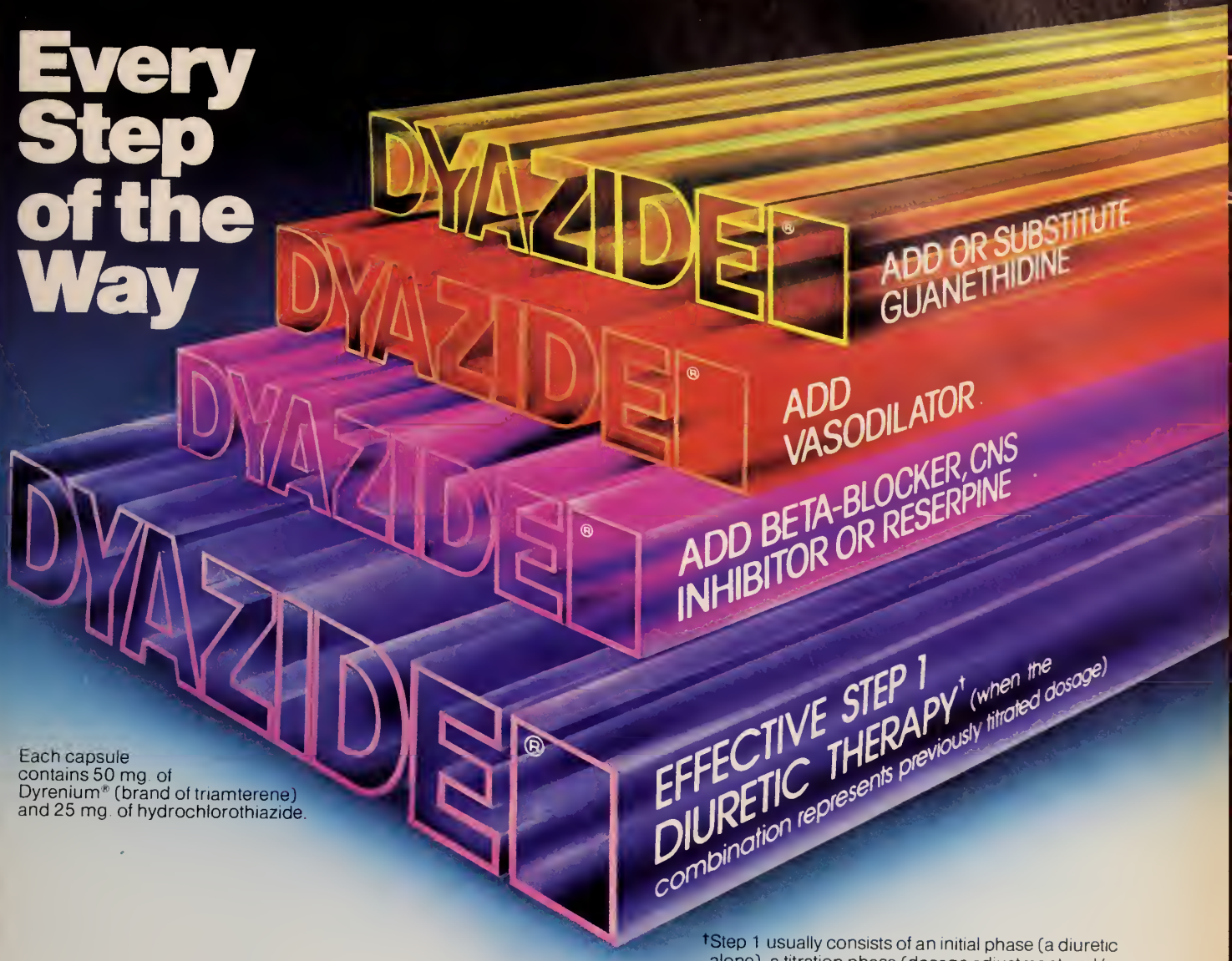
LANIER, DOUGLAS C., Gulfport. Born Louisville, KY, July 30, 1951; M.D., University of Alabama School of Medicine, Birmingham, 1974; interned St. Vincents Hospital, Birmingham, one year; internal medicine residency, Louisiana State University, New Orleans, 1975-77; nephrology residency, University of Miami, Miami, FL, 1978-1980; elected by Coast Counties Medical Society.

DEATHS

BOGGESS, JULIAN E., JR., Columbus. Born Macon, MS, Feb. 13, 1914; M.D., Louisiana State University School of Medicine, New Orleans, 1941; interned Charity Hospital, New Orleans, one year; residency in ophthalmology, EENT Hospital, New Orleans, 1946-1949; died Oct. 9, 1981, age 67.

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

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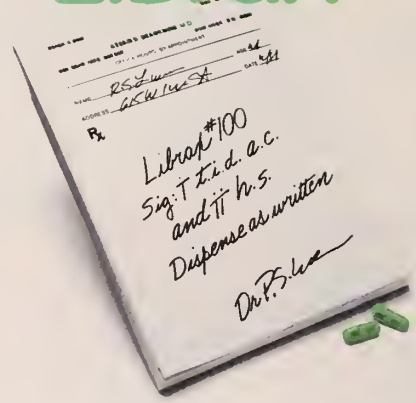
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Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema; minor menstrual irregularities; nausea and constipation; extrapyramidal symptoms; increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis); jaundice; hepatic dysfunction reported occasionally with chlordiazepoxide HCl; making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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Irritable BOWEL SYNDROME*

Artist's concept of myoelectrical slow waves of the colon which seem to determine the frequency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

Librax: A logical choice for patients with IBS

Logical, because the antimotility-antispasmodic actions of the Quarzan®(clidinium bromide/Roche) component of Librax can help to relieve the distressing abdominal symptoms associated with IBS.* Logical, because the antianxiety actions of the Librium® (chlordiazepoxide HCl/Roche) component can help to reduce the excessive anxiety that can contribute to IBS flare-ups.

References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med* 298:878-883, Apr 20, 1978
2. Snape WJ *et al*: *Gastroenterology* 72: 383-387, Mar 1977.

Specify Adjunctive **Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

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*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

for Knotts in the night

Prescribe new formula

Quinamm*

(quinine sulfate tablets)

each tablet contains quinine sulfate 260 mg



Specific therapy for painful night leg cramps

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Quinamm™
(quinine sulfate tablets)

CAUTION Federal law prohibits dispensing without prescription

BRIEF SUMMARY

INDICATIONS AND USAGE
For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS
Quinamm may cause fetal harm when administered to a pregnant woman Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion In about half of these reports the malformation was deafness related to auditory nerve hypoplasia Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys Quinamm is contraindicated in women who are or may become pregnant If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug the patient should be apprised of the potential hazard to the fetus

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use Recovery usually occurs following withdrawal of the medication and appropriate therapy

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever

WARNINGS
Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision, however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine Quinamm should be stopped immediately if evidence of hemolysis appears

If symptoms occur, drug should be discontinued and supportive measures instituted In case of overdosage see OVERDOSAGE section of prescribing information

PRECAUTIONS
General
Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken Extreme flushing of the skin accompanied by intense generalized pruritus is the most common form Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions)

Drug Interactions
Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine

Cinchona alkaloids, including quinine have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium succinylcholine, and tubocurarine) may be potentiated with quinine and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions
Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis Mutagenesis, Impairment of Fertility
A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver homogenate was added, positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy
Category X See CONTRAINDICATIONS

Nonteratogenic Effects
Because quinine crosses the placenta in humans the potential for fetal effects is present Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers
Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS
The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage (Individual or multiple symptoms may represent cinchonism or hypersensitivity)

Hematologic acute hemolysis thrombocytopenic purpura agranulocytosis hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata photophobia diplopia diminished visual fields, and disturbed color vision tinnitus, deafness and vertigo headache nausea vomiting fever apprehension restlessness confusion, and syncope

Dermatologic allergic cutaneous rashes (urticarial the most frequent type of allergic reaction papular or scarlatinal) pruritus flushing of the skin sweating occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related) epigastric pain

DRUG ABUSE AND DEPENDENCE
Tolerance abuse or dependence with Quinamm has not been reported

OVERDOSAGE
See prescribing information for a discussion on symptoms and treatment of overdose

DOSAGE AND ADMINISTRATION
1 tablet upon retiring If needed 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not occur Quinamm may be discontinued in order to determine whether continued therapy is needed

Product Information as of October 1980

Licensor of Merrell*
MERRELL-NATIONAL LABORATORIES Inc
Cayey Puerto Rico 00633

Direct Medical Inquiries to

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1-8137 (Y437CIMNQ-699

PERSONALS

J. Patrick Barrett and William R. Stewart of Jackson announce the association of Gene R. Barrett for the practice of sports medicine, knee surgery and orthopedic surgery.

William Bates of UMC recently conducted a postgraduate course for the American Fertility Society in Maui, Hawaii.

Terrell D. Blanton of Jackson announces the association of C. Ron Cannon for the practice of ear, nose, throat, head and neck surgery, and facial plastic surgery. Dr. Cannon presented a paper at the recent scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery in New Orleans.

Joseph V. F. Clay, Jr. of Whitfield has associated with the Madison County Medical Clinic in Ridgeland.

Frank L. Covington, Jr. announces the opening of his office for the practice of psychiatry at 1213 31st Avenue in Gulfport.

Clyde O. Hagood, Jr. of Biloxi announces the opening of his office for the practice of general surgery and peripheral vascular surgery at Coastal Medical Center Building.

Armin Haerer of UMC presented papers at the American Neurological Association meeting in San Francisco and at a meeting of the International Epidemiological Society in Edinburgh, Scotland.

James Hardy of UMC addressed the International Federation of Surgery conference in Montreux, Switzerland, and accepted honorary membership in the French Association of Surgery in Paris, France, in September.

Gray Hilsman announces the opening of his office for the practice of general psychiatry and neuroforensic psychiatry at 1765 Lelia Drive, Suite 101, in Jackson.

Dan Jackson of Rolling Fork announces the opening of his new office for the practice of medicine at 102 South Forth Street.

Herbert Langford of UMC lectured during a hypertension workshop at St. John's Regional Health Center in Springfield, Missouri, in August.

Robert C. Lee announces the opening of his office for the practice of family medicine at Collinsville Family Practice Center.

Robert D. McBroom and Larry M. Mitchell of Pascagoula announce the association of Alan H. Arrington for the practice of pulmonary diseases, occupational lung diseases and internal medicine.

Gordon Meador has associated with Pediatric Clinic of Tupelo (William Hilbun, Jr. and Edward Ivancic) for the practice of pediatrics.

W. A. Middleton of Winona received that community's Citizen of the Month award in recognition of the renovation work he has done on the old Wisteria Hotel.

Francis Morrison of UMC recently attended an executive board meeting of the South Central Association of Blood Banks in Austin, Texas.

John Morrison of UMC was visiting professor at Marquette University in Milwaukee, Wisconsin.

Winson V. Morrison announces the opening of his office for the practice of ear, nose, throat, head, neck and maxillofacial surgery at the University Medical Center, 2500 North State Street, Jackson.

James S. Poole of Gloster has completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

Philip Rhodes of UMC taught a continuing education course recently at the University of Kansas Medical Center in Kansas City, Kansas, and spoke at a meeting of the Mississippi Association of Surgical Technologists in Biloxi.

Ben Sanford announces the opening of his office for the practice of internal medicine at 306 Lampkin Street in Starkville.

George B. Schimmel announces the opening of his office for the practice of cardiology at 348 Crossgate Boulevard, Suite 2200, Brandon.

William L. Stephenson, Jr. has affiliated with Anesthesia Associates, 301 Medical Plaza Building, 1600 North State Street, Jackson, for the practice of anesthesia.

Raul E. Valenzuela of UMC was guest speaker at the recent quarterly meeting and grand rounds of the Department of Ophthalmology of Tulane Medical School in New Orleans.

PLACEMENT SERVICE

Physicians Wanted

ANESTHESIOLOGIST to join large community hospital. Contact Tom Askew, Administrator, Greenwood-Leflore County Hospital, Greenwood, MS 38930.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

SURGEON to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

SURGEON seeks location in general thoracic and cardiac surgery upon completion of residency in July, 1982. Graduate of Tulane University, 1975. Contact Dr. Kevin M. Keubler, 600 Highland Ave., Madison, WI 53792.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

BOARD ELIGIBLE INTERNIST seeks practice location; M.D. from University of Texas at Southwestern. Contact Stephen R. Cherry, M.D., 7061 B Creekview Trail, St. Louis, MO 63123.

BOARD ELIGIBLE PATHOLOGIST seeks practice opportunity. Graduate of University of Mississippi School of Medicine; residencies, UMC. Contact Marianna G. Pardue, M.D., 315 Cedarwood, Jackson, MS, 39212.

BOARD CERTIFIED FAMILY PRACTITIONER seeks practice location. Currently completing military obligation and available 7/82. Contact John E. Baites, Jr., M.D., 5405 Hackney Circle, Bossier City, LA 71111.

CLASSIFIED

LIKE NEW MEDICAL OFFICE FURNITURE and medical equipment, surgical instruments, etc. Closing down surgery practice; only 18 months old. Contact Dr. Marvin M. Ettinger, Monticello, MS; 587-2524 or 587-4029.

200 MILLIAMPS OFFICE X-RAY UNIT, complete with table, stand and new tube, and tank developing system, pig-o-stat, x-ray file storage, mobile screen, chest plate rack, apron and accessories. $8,000. Available now. Contact Dr. Lyle, Starkville Children's Clinic, P.O. Box 1507, Starkville, MS 39759; (601) 323-7510.

CLAY ADAMS ELECTRONIC cell counter. Performs HGB, RBC, WBC; List $6,950.00 — sacrifice $3,500.00. Contact Robert T. Cates, M.D., (601) 856-6000.

PHYSICIANS

Opportunities in Mississippi

Due to the expansion of our hospitals in small communities and metropolitan areas of Mississippi, we are currently seeking Physicians in the following areas of specialization:

- **Pediatricians**
- **Obstetricians**
- **Internists**

We offer guaranteed income and moving expenses, in addition to other amenities. For consideration, please submit CV to:

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 114th Annual Session, May 2-6, 1982, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 30-July 3, 1982, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

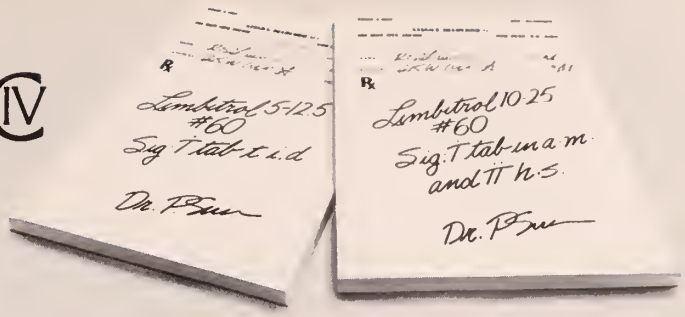
Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)



In anxious depression,

SPECIFIC FOR THE NONPSYCHOTIC PATIENT

Fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician[1] found a correlation of 0.7 in anxiety and depression scores; another[2] has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

More appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.[2,3]

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Clagharn J: *Psychosomatics 11* 438-441, Sept-Oct 1970. **2.** Rickels K Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crafts, 1977, p 316 **3.** Baldessarini RJ, Tarsy D Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascia A, Killam KF New York, Raven Press, 1978, p 999

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

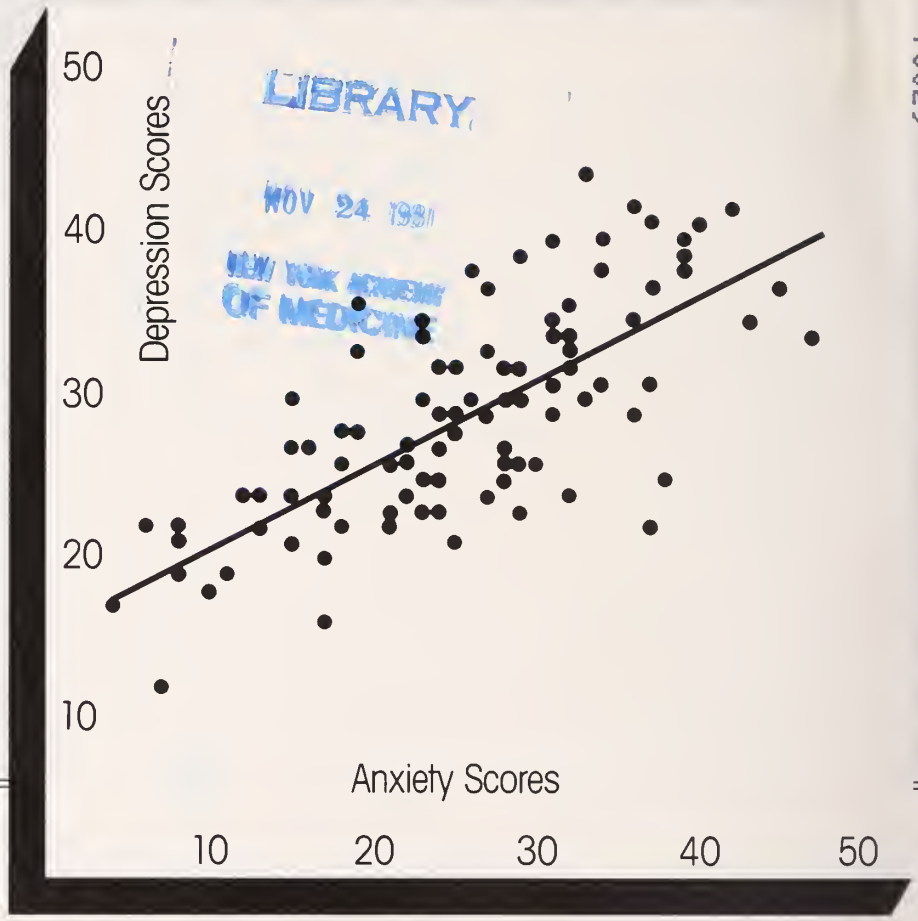
Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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MORE DEPRESSION MEANS MORE ANXIETY...



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The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.
—Adapted from Clagharn J[1]

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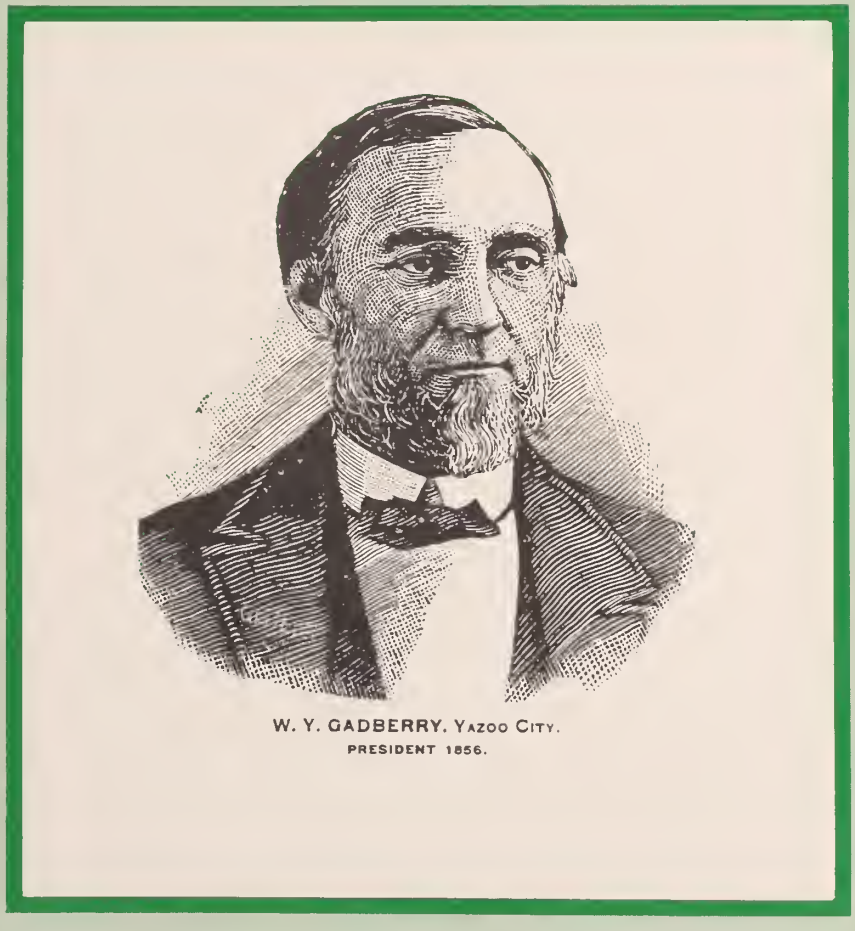
1. Clagharn J: *Psychosomatics* 11:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.

NEW YORK N.Y. 10029

December 1981

JOURNAL of the MISSISSIPPI State Medical Association

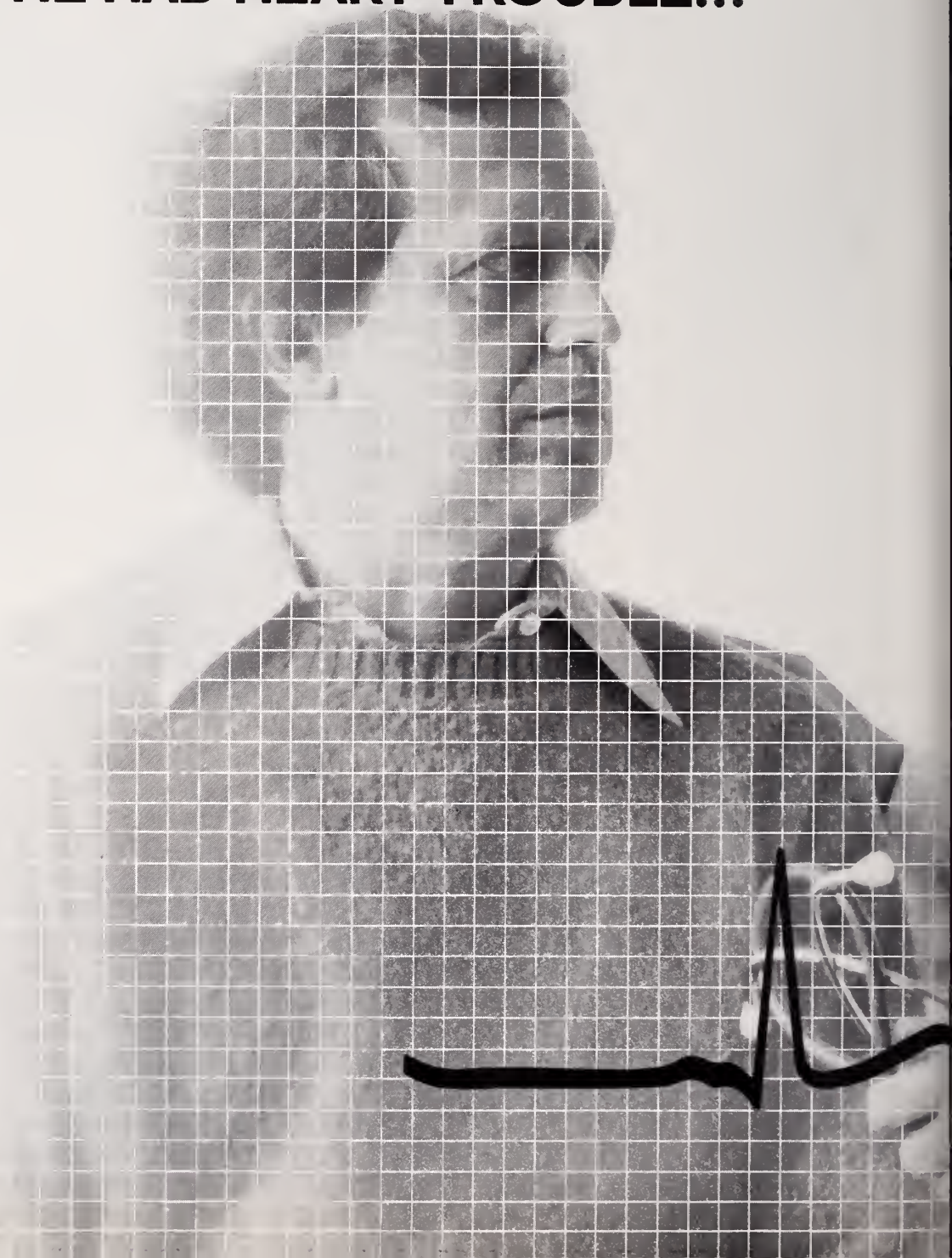


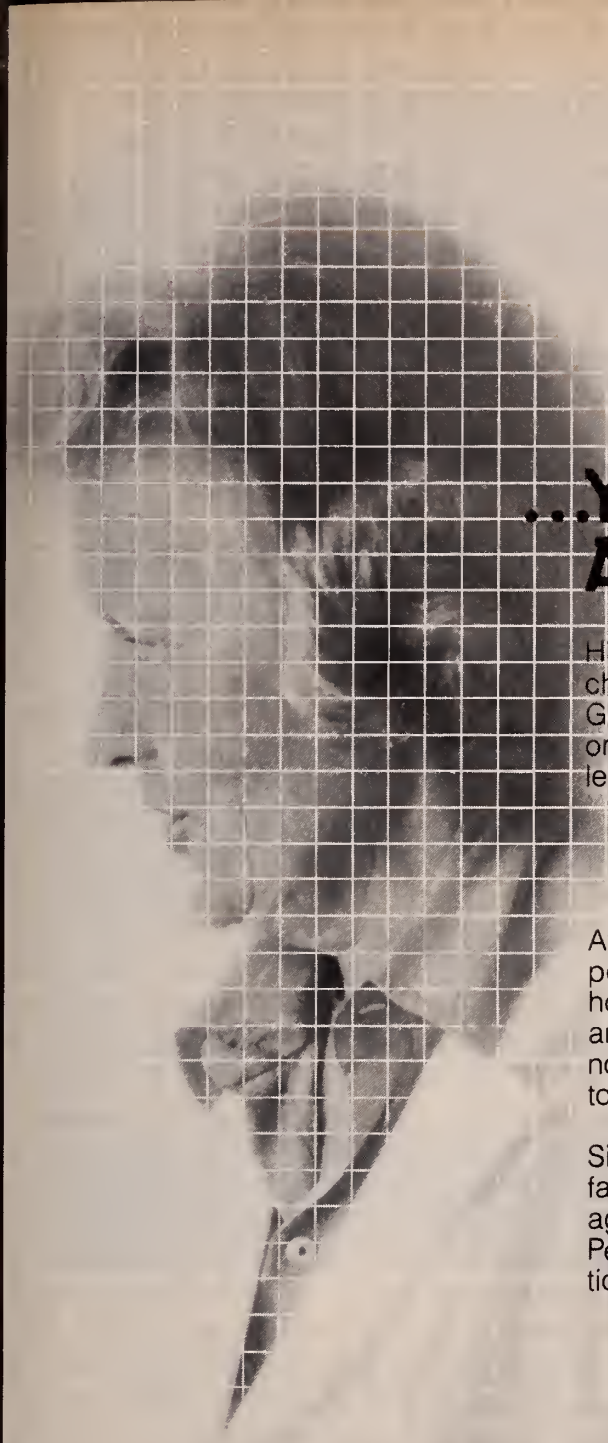
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SPECIAL ISSUE

125th Anniversary — Looking Back

THE PATIENT THINKS HE HAS HEART TROUBLE...





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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December 1981, Volume XXII, Number 12 — 125th Anniversary Special Issue

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Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT
- Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
- Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
- Otitis media caused by S. pneumoniae (formerly D. pneumoniae) and *H. influenzae*
- Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, nonpenicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin *Structures*	250 mg to 500 mg q.i.d †	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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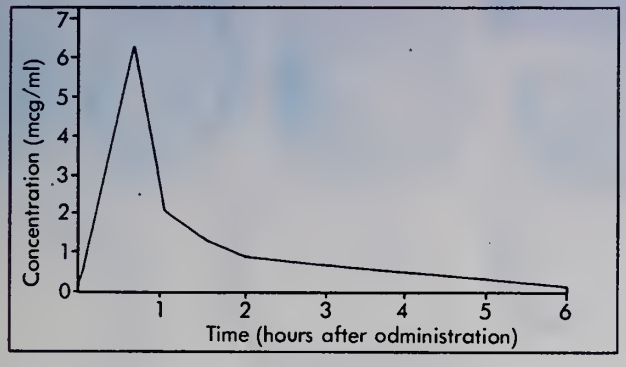
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Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92%	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	
Streptococcol Sore Throat†		
Group A beto-hemolytic Streptococcus	100%	44
	86%	
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†Due to susceptible organisms.

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We Care!

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of Mississippi

NEWSLETTER

December 1981

Dear Doctor:

December 15, 1856 was the date of the founding of the Mississippi State Medical Association. This issue of Journal MSMA commemorates the 125th anniversary of the association with special articles and pictorial features. The issue was compiled with the help of many people who responded to a call for historical material. We are indebted to all who contributed material and pictures, who gathered information, and who donated their time to make the issue possible.

> We received more material than could be used in a single issue, and at press time information and article ideas continued to come. Future issues will devote space to historical features which we hope will be of interest. We encourage you to continue to contact your journal office if you have historical information or pictures to share.

A committee of your MSMA past presidents has planned other activities to celebrate the association's 125th anniversary. One is the establishment of a country doctor's office at the Mississippi Agriculture and Forestry Museum in Jackson. Your contributions are needed to construct and furnish the exhibit. Your tax-deductible donation, made payable to the Museum Foundation, can be mailed to MSMA headquarters.

Physicians wishing to present a scientific exhibit at the 114th Annual Session are urged to send letters requesting exhibit space to the chairman, scientific exhibits, MSMA, P.O. Box 5229, Jackson, MS 39216. Letters should give the title of the proposed exhibit and indicate the approximate number of linear feet the exhibit requires. Space is limited, so early application is urged.

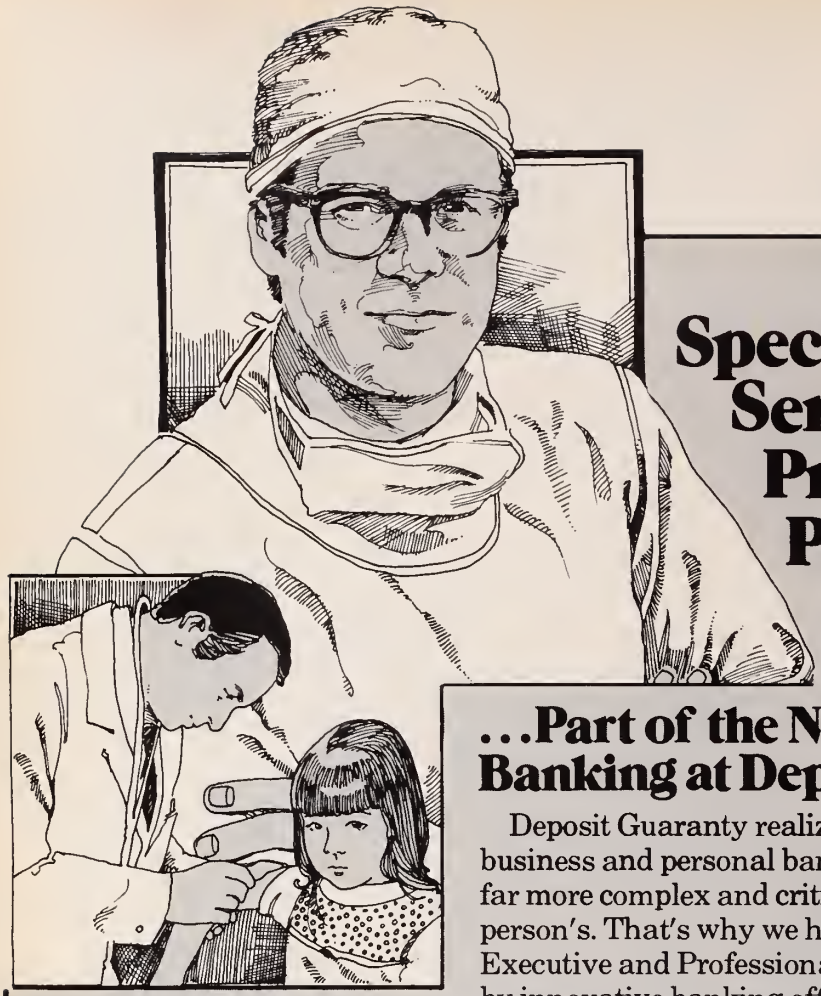
Syndicated columnist and lecturer Abigail Van Buren will be the guest speaker for the MSMA/MSMA Auxiliary banquet scheduled during the 114th Annual Session, May 2-6, 1982, in Biloxi. Future issues of Journal MSMA will include information on all activities, including: tennis, golf, fishing and jogging events; scientific sessions, alumni meetings, House of Delegates, and special anniversary party.

The staff and officers of the Mississippi State Medical Association wish for all members and their families a most joyous holiday season and a happy and healthy year in 1982. During the holiday season and always, "May you have the spirit of Christmas, which is Peace; the gladness of Christmas, which is Hope; the heart of Christmas, which is Love."

Sincerely,

Patsy Silver

Patsy Silver
Managing Editor



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Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
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Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

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Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease. Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age ½ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age ½ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

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Safe:

"...can be safely administered for prolonged periods..."[3]

Freedom from long-term toxicity permits use of extended therapeutic courses of NIZORAL, when indicated, and provides an extra margin of safety in presumptive antifungal therapy. Long-term administration has revealed no organ toxicity and no consistent changes in important hematological or biochemical values. Infrequent, transient increases in serum liver enzymes have been seen. Adverse reactions were generally minor and only rarely required withdrawal of therapy.

Convenient:

once-a-day oral regimen fosters compliance...facilitates use both in and out of the hospital.

*Includes cases in remission or markedly improved (no evidence of active disease); both mycological and clinical criteria were considered in measuring overall response.

For further information on NIZORAL write: Professional Services, Janssen Pharmaceutica Inc., 501 George St., New Brunswick, N.J. 08903.

See the facing page for Complete Prescribing Information.

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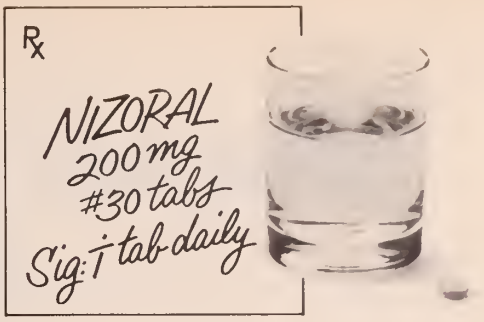
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JANSSEN PHARMACEUTICA

NEW orally effective

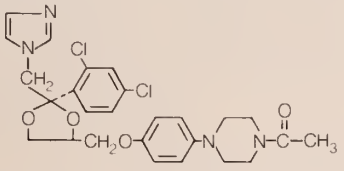
NIZORAL™ TABLETS
(ketoconazole)

One tablet a day provides broad-spectrum antimycotic efficacy



DESCRIPTION

NIZORAL™ (ketoconazole) is a synthetic broad-spectrum antifungal agent available in scored white tablets, each containing 200 mg ketoconazole. Ketoconazole is *cis*-1-acetyl-4-[4-[[2-(2,4-dichlorophenyl)-2-(1*H*-imidazol-1-ylmethyl)-1,3-dioxolan-4-yl]methoxy]phenyl]piperazine and has the following structural formula



NIZORAL™ is a white to slightly beige, odorless powder, soluble in acids, with a molecular weight of 531.44.

CLINICAL PHARMACOLOGY

Mean peak plasma levels of approximately 3.5 μg/ml are reached within 1 to 2 hours, following oral administration of a single 200 mg dose taken with a meal. Subsequent plasma elimination is biphasic with a half-life of 2 hours during the first 10 hours and 8 hours thereafter. Following absorption from the gastrointestinal tract, NIZORAL™ is converted into several inactive metabolites. The major identified metabolic pathways are: oxidation and degradation of the imidazole and piperazine rings, oxidative O-dealkylation and aromatic hydroxylation. About 13% of the dose is excreted in the urine, of which 2 to 4% is unchanged drug. The major route of excretion is through the bile into the intestinal tract. *In vitro*, the plasma protein binding is about 99%, mainly to the albumin fraction. Only a negligible proportion of NIZORAL™ reaches the cerebral spinal fluid. NIZORAL™ is a weak dibasic agent and thus requires acidity for dissolution and absorption.

NIZORAL™ is active against clinical infections with *Candida* spp., *Coccidioides immitis*, *Histoplasma capsulatum*, *Paracoccidioides brasiliensis*, and *Phialophora* spp. Development of resistance to NIZORAL™ has not yet been reported.

The following preclinical data are available; however, their clinical significance is unknown. NIZORAL™ is active *in vitro* against dermatophytes, dimorphic fungi, eumycetes, yeasts, actinomycetes, phycomycetes and various other fungi. In animal models, activity has been demonstrated against *Candida* spp., dermatophytes (*Trichophyton* spp., *Microsporum* spp., *Epidermophyton floccosum*), *Blastomyces dermatitidis*, *Histoplasma capsulatum*, *Malassezia furfur*, *Coccidioides immitis*, and *Cryptococcus neoformans*.

Mode of Action: *In vitro* studies suggest that NIZORAL™ impairs the synthesis of ergosterol, which is a vital component of fungal cell membranes. Tests in animals suggest this mechanism is not important in mammalian cells.

INDICATIONS AND USAGE

NIZORAL™ is indicated for the treatment of the following fungal infections: candidiasis, chronic mucocutaneous candidiasis, oral thrush, candiduria, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis. NIZORAL™ should not be used for fungal meningitis because it penetrates poorly into the cerebral-spinal fluid.

For the initial diagnosis, the infective organism should be identified, however, therapy may be initiated prior to obtaining laboratory results.

CONTRAINDICATIONS

NIZORAL™ is contraindicated in patients who have shown hypersensitivity to the drug.

WARNINGS

In female rats treated three to six months with ketoconazole at dose levels of 80 mg/kg and higher, increased fragility of long bones, in some cases leading to fracture, was seen. The maximum "no-effect" dose level in these studies was 20 mg/kg (2.5 times the maximum recommended human dose). The mechanism responsible for this phenomenon is obscure. Limited studies in dogs failed to demonstrate such an effect on the metacarpals and ribs.

PRECAUTIONS

General: In four subjects with drug-induced achlorhydria, a marked reduction in NIZORAL™ absorption was observed. NIZORAL™ requires acidity for dissolution. If concomitant antacids, anticholinergics, and H_2-blockers are needed, they should be given at least two hours after NIZORAL™ administration. In cases of achlorhydria, the patients should be instructed to dissolve each tablet in 4 ml aqueous solution of 0.2 N HCl. For ingesting the resulting mixture, they should use a glass or plastic straw so as to avoid contact with the teeth. This administration should be followed with a cup of tap water.

Drug Interactions: There is no evidence for clinically significant interaction with oral anticoagulant or oral hypoglycemic agents.

Carcinogenesis, Mutagenesis, Impairment of Fertility: The dominant lethal mutation test in male and female mice revealed that single oral doses of NIZORAL™ as high as 80 mg/kg produced no mutation in any stage of germ cell development. The Ames' *Salmonella* microsomal activator assay was also negative.

Pregnancy: Teratogenic effects. *Pregnancy Category C.* NIZORAL™ has been shown to be teratogenic (syndactylia and oligodactylia) in the rat when given in the diet at 80 mg/kg/day, (10 times the maximum recommended human dose). However, these effects may be related to maternal toxicity, evidence of which also was seen at this and higher dose levels.

Nonteratogenic effects. NIZORAL™ has also been found to be embryotoxic in the rat when given in the diet at doses higher than 80 mg/kg during the first trimester of gestation.

In addition, dystocia (difficult labor) was noted in rats administered NIZORAL™ during the third trimester of gestation. This occurred when NIZORAL™ was administered at doses higher than 10 mg/kg (higher than 1.25 times the maximum human dose).

It is likely that both the malformations and the embryotoxicity resulting from the administration of NIZORAL™ during gestation are a reflection of the particular sensitivity of the female rat to this drug. For example, the oral LD_{50} of NIZORAL™ given by gavage to the female rat is 166 mg/kg, whereas in the male rat the oral LD_{50} is 287 mg/kg.

Nursing Mothers: Since NIZORAL™ is probably excreted in the milk, mothers who are under NIZORAL™ treatment should not breast-feed the child.

Pediatric Use: Safety in children under two years of age has been documented in a limited number of cases.

ADVERSE REACTIONS

NIZORAL™ is usually well tolerated. Most adverse reactions reported have been mild and transient and have only rarely required withdrawal of therapy.

The most frequent adverse reactions were nausea and/or vomiting, which occurred in approximately 3% of patients. Abdominal pain was reported in approximately 1.2% of patients; pruritus in approximately 1.5% of patients. The following have been reported in less than 1% of patients: headache, dizziness, somnolence, fever and chills, photophobia, and diarrhea. Infrequent, transient increases in serum liver enzymes have been seen.

OVERDOSAGE

In the event of accidental overdosage, supportive measures, including gastric lavage with sodium bicarbonate, should be employed.

DOSAGE AND ADMINISTRATION

Adults: The recommended starting dose of NIZORAL™ is a single daily administration of 200 mg (one tablet). In very serious infections or if clinical responsiveness is insufficient within the expected time, the dose of NIZORAL™ may be increased to 400 mg (two tablets) once daily.

Children:

Children weighing 20 kg or less:	50 mg (¼ tablet) once daily
Children weighing 20-40 kg:	100 mg (½ tablet) once daily
Children weighing over 40 kg:	200 mg (1 tablet) once daily

Generally, treatment should be continued until all clinical and laboratory tests indicate that active fungal infection has subsided. Inadequate periods of treatment may yield poor response and lead to early recurrence of clinical symptoms. Minimum treatment for candidiasis is one or two weeks. Patients with chronic mucocutaneous candidiasis usually require maintenance therapy. Minimum treatment for the other indicated systemic mycoses is six months.

HOW SUPPLIED

NIZORAL™ is available as white, scored tablets containing 200 mg of ketoconazole debossed "JANSSEN." They are supplied in bottles of 60 tablets.

U.S. Patent Pending
NDC 50458-220-06 (60 tablets)

May 1981

Manufactured by:
Janssen Pharmaceutica n.v.
B-2340 Beerse, Belgium

For:
Janssen Pharmaceutica Inc.
New Brunswick, New Jersey 08903 USA

References:

1. Negroni R, Robles AM, Arechavala A, et al: Ketoconazole in the treatment of paracoccidioidomycosis and histoplasmosis. *Reviews of Infectious Diseases* 2 (4): 643-648, 1980. **2.** Data on file, Janssen Pharmaceutica. **3.** Graybill JR, Lundberg D, Donovan W, et al: Treatment of coccidioidomycosis with ketoconazole: Clinical and laboratory studies of 18 patients. *Reviews of Infectious Diseases* 2 (4): 661-673, 1980.

Committed to research...
because so much remains to be done.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
December 1981, Vol. XXII, No. 12

SPECIAL ARTICLES

History of the Mississippi State Medical Association

CHARLES L. MATHEWS

THERE HAS BEEN an official *History of the Mississippi State Medical Association* published on two occasions. The first was published in 1910. It was compiled by the secretary of the association, Dr. E. F. Howard of Vicksburg, in collaboration with Drs. H. L. Sutherland of Rosedale and J. C. Hall of Anguilla. Dr. Howard served as secretary of the association from 1907 to 1918 and later was elected president in 1930-31.

The second history was published in 1949 by the "historian" of the association, Dr. James Grant Thompson of Jackson. Dr. Thompson also later became president of the association, serving in that office in 1951-52.

Parenthetically, it should be noted at this time that a third edition of the *History of the Mississippi State Medical Association* is scheduled for publication next year. It will cover the period from 1950 to 1981.

Dr. Thompson's description of how he was elected "historian" of the association is perhaps of interest to those who have been present (or absent) at a meeting of the MSMA House of Delegates. In his introduction to the second history he stated:

> "While sitting peacefully in the House of Delegates in 1944, and listening more or less, to the motions and discussions of my elders, the discussion of a new Historian for the association came up, and before any real protest on my part could be made, it happened; and I found myself thrust into the position of Historian. . . ."

Editorial note: In researching various written materials for an article that would provide highlights of the 125 year history of the Mississippi State Medical Association, one is impressed by the fact that there are more peaks than valleys. There are, however, limits on space, if not the reader's attention, so this article will necessarily not include all the highlights of the oldest professional association in Mississippi.

The first history of the association covered the period 1856 to 1906. Dr. Fox had very little available material to refer to in compiling the history. In his words, "there was not even a file of the official *Transactions,* due to the fact that at least twice the secretary's office had been wiped out by fire." He apparently spent many hours gathering information about the association's early years.

After publication of the first history, Dr. Fox continued to compile information for a second history until his death in 1933. His efforts were noted by Dr. Thompson, who stated that they came ". . . from a sheer love of wanting to do something for his (professional) association."

With this background, some of the highlights of the history of the Mississippi State Medical Association from 1856 to 1949 are:

1856 — Jackson

The association held its first organizational meeting and elected Dr. W. Y. Gadberry of Benton, president. "The association adjourned to meet on the second Monday in November, 1857 but there was no other meeting until 1869."

1869 — Vicksburg

The association prepared "an address to the people of the state respecting the importance of a more perfect system of drainage upon plantations

with a view to so far as possible arresting the production of miasma, so fruitful as a source of grave forms of fever.''

1877 — Grenada
The association called for establishment of a State Board of Health.

1879 — Aberdeen
It was reported that some twenty members of the association, nearly ten per cent of the membership, died in the great yellow fever epidemic of 1878.

1880 — Vicksburg
The association began efforts to enact legislation ''to regulate the practice of medicine in the state.''

1890 — Meridian
''On several previous occasions the minutes of meetings of the association record the expulsion of a member for unprofessional conduct, but here is a record of a member being called before the president and by him publicly reprimanded in open meeting; a remarkable testimony to the loyalty and self control of the member especially when we consider how comparatively feeble the association was at the time.''



Dr. W. Y. Gadberry of Yazoo City was the first president of the Mississippi State Medical Association. He was elected at the organizational meeting, December 15, 1856. Dr. M. S. Craft of Jackson was named recording secretary.

1895 — Jackson
The association called for establishment of a medical department of the state university.

1897 — Jackson
The *Mississippi Medical Record* was named as the association's official publication.

1902 — Jackson
The association called for enactment of legislation to equalize the salaries and duties of county health officers and to provide that county coroners be doctors.

1903 — Jackson
The association adopted an AMA plan for a nationwide federation of state and county medical societies.

1904 — Jackson
The *Journal of the Mississippi State Medical Association* was adopted as the association's official publication. Its name was changed to the *Mississippi Medical Monthly* in 1906.

1907 — Gulfport
The association began efforts to enact legislation to require a diploma as a prerequisite for examination to practice medicine in the state.

1909 — Jackson
The association urged passage of a compulsory vaccination law for school children.

1910 -- Oxford
The association supported appointment of the state's first full time state health officer, Dr. W. S. Leathers of Oxford.

1911 — Jackson
The association established a ''medico-legal defense fund'' to defend members charged with malpractice.

1915 — Hattiesburg
The association urged establishment of a state hospital for tubercular patients.

1917 — Jackson
The association turned the site of its meeting into a recruiting station for World War I.

1924 — Jackson
The *New Orleans Medical and Surgical Journal* was named as the association's official publication.

1925 — Biloxi
The association called for legislation to protect



Dr. Ewing Fox Howard of Vicksburg compiled the first history of the association. He was elected secretary in 1907, and for three years he worked to assemble material for the volume.



Dr. James Grant Thompson of Jackson edited the second history of MSMA. The House of Delegates named him historian of the association in 1944, and he brought the volume forward to 1949.

children from burns by lye and similar commodities in the home.

1927 — Jackson
The association contributed $2,000 for relief of flood victims in the Delta.

1931 — Jackson
The association called for a state subsidy for small community hospitals.

1934 — Natchez
The association formulated a fee schedule for use under the Federal Emergency Relief Act.

1936 — Greenville
The Mississippi Doctor was adopted as the association's official publication.

1937 — Meridian
The association appointed a committee to work with the Mississippi Hospital Association to implement a non-profit hospital insurance plan. (Blue Cross)

1938 — Jackson
The association supported establishment of an "Isolation Hospital for Polio" and Cancer and Crippled Children's Annexes at the State Charity Hospital in Jackson.

1943 — Jackson
The association supported establishment of a four year medical school "provided that it can be set up free of political domination to insure its practical operation."

1945 — Jackson
The association urged enactment of a state scholarship fund for medical students who agreed to practice in a rural area.

1946 — Jackson
The association urged enactment of state legislation required to participate in the Hill-Burton Program. ★★★

The Charter of Incorporation of the Mississippi State Medical Association

c1. Be it known that A.N. Haralson, M.J. Lowry, R.E. Howard, J.R. Tackett, C.N. Trotter, J.F. Hunter, D.S. Humphreys, C.S. Bradley, J.D. Smyth, E.C. Coleman, C.C. Jones, W.S. Sims, T.B. Hammond, W.D. Easterland and B.L. Cully, and their Associates and Successors are hereby incorporated under the Name and Style of "The Mississippi State Medical Association," and by this Name shall be known and designated, shall sue and be sued, plead and be impleaded, in any Courts of this State.

c2 Said Corporation may acquire and transmit real and personal estate; adopt a Corporate Seal and alter or change the same at pleasure.

c3 Said Corporation shall exist for fifty years, and may adopt any by-laws not inconsistent with the Constitution and laws of the State of Mississippi; may adopt a Code of ethics, and Means to enforce the same, and prescribe the terms and Conditions of its Membership; May elect and prescribe the duties of all officers for its Self-Government; May prescribe the terms and Conditions upon which local Medical Associations in the State can be represented in this association; and shall have all the rights, powers, privileges and immunities granted to similar Corporations in Chapter 26 of the Annotated Code of Mississippi 1892, which are Necessary and proper for Carrying out the Purposes of this Charter.

c4 The objects and Purposes of this Corporation shall be the advancement of Knowledge upon all Subjects Connected with the healing art, the Elevation of Character and the Protection of the Proper rights and interests of those engaged in the practice of Medicine, and the study of the Means Calculated to render the Medical Profession Mash useful to the Public, and Subservient to the great interests of humanity.

c5. This Charter shall go into effect and be in force from and after its approval by the Governor, and the domicile shall be the City of Jackson, in the County of Hinds and State of Mississippi.

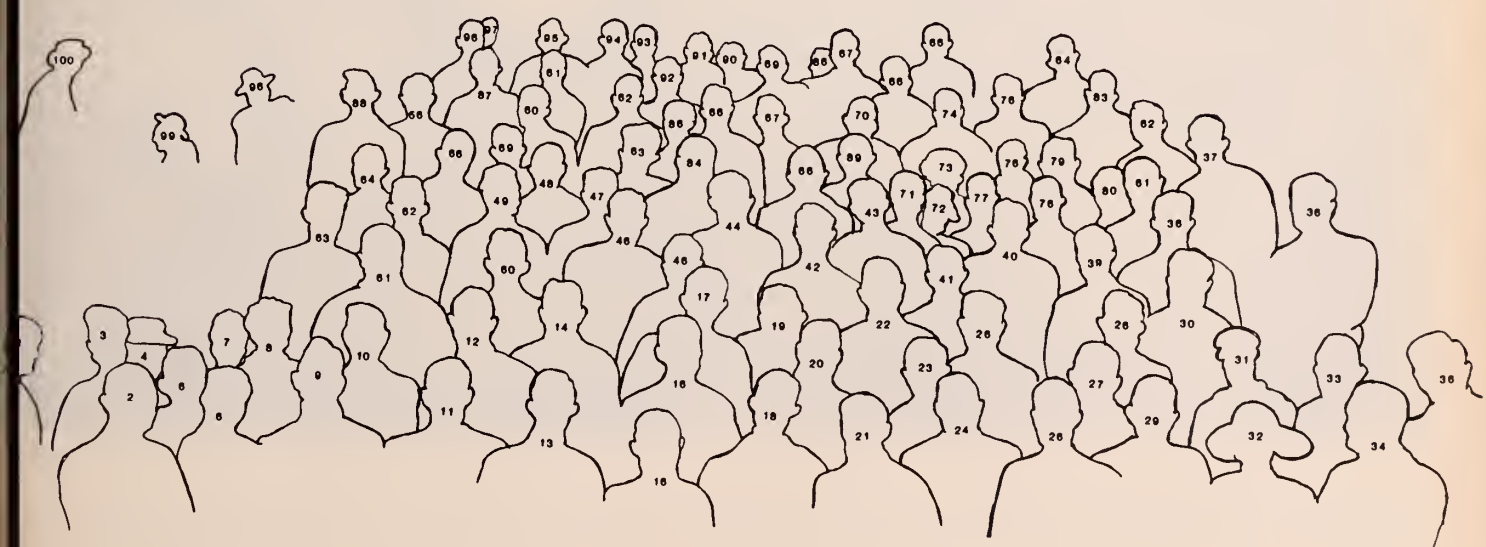
The foregoing proposed Charter of incorporation is respectfully referred to the Hon. atty. Gen. for his advice as to the Constitutionality & Legality of the Provisions thereof. Jackson Miss. Sept 18th 1895 J.M. Stone Gov

The provisions of the foregoing proposed Charter of incorporation are not violative of the Constitution or laws of the State.

Jackson Miss. Sept. 18th 1895 Frank Johnston — atty Genl

Can You Identify Any of the MSMA Members Who Attended the 1928 Annual Session?

(See photo next page)




ANNUAL CONVENTION OF MISS. STATE
MEDICAL ASSOCIATION 5-7-8-9-28
PHOTO
HAMMON





The Mississippi State Asylum was located on North State Street in Jackson, where the University Medical Center is now. Members of the asylum staff in 1923 are pictured in front of one of the asylum buildings. From left are: Dr. C. D. Mitchell, superintendent; Dr. I. Whitten, staff dentist; Dr. Ross Anderson; Dr. G. T. Sheffield; Dr. Turner Googe; Dr. M. E. Clark; Dr. Johnson; and Dr. Brown, clinical director.

The Component Society — A "Sine Qua Non" to Membership

CHARLES L. MATHEWS

ORGANIZATION OF MSMA's component (county) medical societies began in 1902-1903 in accordance with a plan of the American Medical Association to create a national federation of state and county medical societies. Urging adoption of the plan in his president's address to the 1903 MSMA Annual Session in Vicksburg, Dr. H. L. Sutherland of Rosedale stated in part:

> The central idea in the plan is to promote the organization of county societies and to make membership in them constitute and be a "sine qua non" to membership in the state body. The county society is primarily a business body to foster the interests of the medical profession, to cultivate our social relations and bring us into closer touch with each other, to engender a more cordial fraternal feeling, to originate measures of state interest and present them to the state association, and to report cases or read papers and discuss them if so desired. . . . "In union there is strength" is a proverb as true as it is trite, and if we could weld the doctors of Mississippi into one active, harmonious body, acting under the inspiration to keep our state up with the foremost in all that pertains to our profession, we would not have long to wait before our endeavors would reach fruition.

Apparently, Dr. Sutherland's organizational call was taken to heart because at the 1904 MSMA Annual Session in Jackson the secretary of the association, Dr. J. J. Haralson of Forest, reported that 46 counties had been organized with a total membership of 520, a net gain of 378 members.

Over the succeeding years the county societies organized and reorganized into larger entities so that today the 82 counties of the state are organized into 18 MSMA component medical societies.

JOURNAL MSMA requested and received several commentaries on the organization of the current component societies of the association, and we wish to express our appreciation to the following persons for their assistance in this regard: Dr. Lawrence W. Long, Jackson (Central Medical Society); Dr. and Mrs. Martin E. Hinman, Vicksburg (West Mississippi Medical Society); Dr. William L. Bass, Jr., Gulfport and Dr. C. D. Taylor, Pass Christian (Coast Counties Medical Society).

Central Medical Society

A Hinds County Medical Society is first listed in the 1904 *Transactions of the Mississippi State Medical Association*. Dr. Julius Crisler, W. L. Britt, B. L. Culley, E. H. Galloway, S. H. McLean and T. J. Mitchell were among those listed on the membership rolls of the Society who were well known in the practice of medicine at the time.

In 1912-1913 Hinds and Rankin counties joined to form the Hinds-Rankin County Medical Society. Drs. J. H. Fox, J. C. Herrington, F. E. Rehfeldt and S. L. Hollingsworth were listed as doctors at the old asylum. Among other doctors who were listed on the membership rolls who became well known over the next 15 to 20 years were Drs. A. S. Applewhite, W. L. Britt, W. B. Dobson, E. H. Galloway, S. H. McLean, G. W. F. Rembert, H. R. Shands. W. W. Smithson, W. H. Watson and Noel C. Womack, Sr.

During 1918-1919 Hinds, Rankin, Madison and Yazoo counties joined together to form the "Central County Medical Society." At this time Drs. J. B. Anderson, J. Darrington, J. Crisler, W. E. Noblin, W. D. McCalip, and O. H. Swayze from Yazoo County made quite an addition to the rolls of the society. It was also reported that "the return of the boys from the war gave a renewed spirit and interest in the society."

In 1921-1922 Simpson County joined the "Central Medical Society" composed then of Hinds, Rankin, Madison and Yazoo counties.

In 1928 a member of the society, Dr. R. N. Whitfield, was in charge of medical licensure and issued temporary licenses to practice medicine until the Board of Health issued a permanent license. The society met in the Chamber of Commerce offices, which were on Capitol Street in Jackson near what is now Primos Restaurant. Dr. R. W. Hall was secretary of the Society.

Scott (1934-1935) and Leake (1936-1937) counties later joined the society to comprise its present membership. Dr. Lawrence W. Long was secretary of the society during this period.

During this century, Central Medical Society has

grown from a small one county society to a seven county society composed of over 600 members, mostly from Hinds County. Jackson in turn has grown to become the state's major medical center.

West Mississippi Medical Society

History was undoubtedly being made throughout the 78-year life of the West Mississippi Medical Society, but the absence of minutes books prior to 1952 makes it difficult to unlock the secrets of the past.

A copy of the August 1903 charter reveals that the organization was originally known as "The Warren County Medical Society," and lists Dr. R. A. Quin as president, and Dr. E. F. Howard as secretary.

A second charter, issued in August 1927, refers to the group as the Issaquena-Sharkey-Warren county Medical Society." Dr. Edley H. Jones was president, and Dr. Leon S. Lippincott was secretary. Dues in 1927 were $5.00 per annum.

The 1903 charter is signed by state president Dr. Charles D. Mitchell, the grandfather of Dr. Tom Mitchell, who currently represents West Mississippi in the House of Delegates of the Mississippi State Medical Association. Dr. E. F. Howard, mentioned in the same document, went on to become president of the state association in 1930-1931.

After Dr. Howard's death in 1935, his widow turned over a suitcase full of memorabilia to Dr. and Mrs. Willard H. Parsons. It has since awaited its destiny in the basement of the Parsons' home and yielded the following items which appeared in 1930 and 1931.

"On Thursday, June 10, the first of two joint meetings of the Fifth District Medical Society of Louisiana and the Tri-County Medical Society of Mississippi will be held in Monroe." Tri-county was yet another name for the West Mississippi Medical Society. In a letter to local physicians, Dr. Lippincott referred to the "fine entertainment those good fellows in Louisiana are planning," and suggested, "it is probably best to go (to Monroe) by train. We can have an enjoyable party on the train on the trip over and back."

One hundred twelve attended a similar get-together in December, which was held in Vicksburg. "A feature of the meeting was the presence of the president and vice-president of the Southern Medical Association and three presidents of state associations."

Among the projects described in 1930 was a vote "to request the Warren County Health department to establish a list of patients who have recovered from infantile paralysis with a view to obtaining serum for treatment."

The Mississippi State Medical Association held its annual meeting in Vicksburg May 13, 1930, at the YMCA. It was at this time that Dr. Howard was chosen as state president. Names figuring prominently in the proceedings were Dr. Hugh Gamble, Greenville; Drs. John C. Cully and P. W. Rowland, Oxford; Dr. F. J. Underwood, Jackson; and Dr. Henry Boswell, Sanatorium.

Among members who were particularly active in West Mississippi's early years were Dr. E. F. Howard, Dr. Augustus Street, Dr. W. H. Parsons, Dr. J. A. K. Birchett, Dr. Preston Street Herring, Dr. George M. Street, and Dr. C. Jarratt.

It was not necessary to present a weighty paper in order to be immortalized in the minutes of the West Mississippi Medical Society. To wit, the following excerpt from the April 13, 1971 records:

"After the evening meal, the vice-president, Dr. Charles Marascalco, introduced Dr. Tom Mitchell, who in turn introduced Dr. Messina, who in turn introduced Dr. Wiygul, who presented the program." Dr. Wiygul then introduced three nurses, Mrs. Grant, Mrs. Crozier and Mrs. Little.

Some problems tackled by West Mississippi over the years were fleeting — for instance, this matter from the minutes of April 9, 1968:

> "It was brought out that on two separate occasions local ambulances ran out of gas while transporting some very seriously injured patients and finally reached the hospital by being towed by one of the local wrecker services. On another occasion, it was reported that two ambulances arrived at the scene of an accident at the same time and the ambulance picked to bring the victim to the hospital was decided by a fist fight. On still another occasion, an ambulance driver brought the patient to the hospital and the driver was reminded by one of the doctors that he had failed to turn off the engine to his car, upon which he replied that if he turned the engine off he would be unable to start the motor again. Dr. Messina made a motion that a committee be formed to investigate."

And some situations are always with us. Take this example from the minutes of March 11, 1958. "Then there was a discussion of local chiropractors. Dr. Joseph Moore pointed out that a local pharmacist's wife had broken a bone in her arm and that soon afterward a local chiropractor had called her offering his service. Dr. Hugh Johnson then read an advertisement of a local chiropractor relative to cancer treatment. Dr. Herring suggested that since the medical society is not a legislative body that we continue to ignore the chiropractors. Dr. Gus Street

suggested that the matter be turned over to the County Attorney.''

Coast Counties Medical Society

This account of the history of the Coast Counties Medical Society is incomplete, as some of the records have been victims of natural disasters; other went unrecorded and faded from memory.

The Coast Counties Medical Society has brought into one organization the physicians of the area to increase the effectiveness of professional opinion on scientific, legislative, public health, and socio-economic issues.

It had its beginning as the Harrison County Medical Society. It was founded in Gulfport by Drs. E. C. Parker, Dan Williams, C. A. Sheeley, and H. M. Folkes in 1904, and had monthly meetings. In 1919 they united with the Stone County Group and became the Harrison-Stone Medical society. Dr. Parker was elected president in 1920. This society in December 1928 became the Harrison-Stone-Hancock Medical Society. In 1937 the Jackson County Society joined them. At a meeting on May 5, 1937, Dr. Riley Burnett made a motion to change the name to the Coast Counties Medical Society.

On May 20, 1938, a charter was issued by the Mississippi State Medical Association to the Coast Counties Medical Society, Dr. W. W. Lake, president and Dr. D. L. Hollis, secretary. The society boasted of 58 members and one honorary member, Dr. W. W. Ely of Biloxi. Members elected a vice-president from each of the counties represented, Harrison, Jackson, Hancock, and Stone. Meetings were held monthly in one of the officer's homes. Scientific papers were the highlights of the meetings, and at times as many as three papers were delivered at one meeting. On March 4, 1942, Dr. Marshall of Appleton, Wisconsin, delivered a paper on the use of liver extract in acne and keloids. The presentation used both still and moving pictures; and while the members failed to be impressed by the improvement of the patients, they were impressed by the quality of the pictures.

The year 1942 found the country at war, and the society notified the public that due to tire and gas rationing, calls would have to be grouped. There would be no night calls after 9:00 p.m. except as an emergency. Drs. Cummings McCall and Archie Hewes served as presidents of the society in the early 1940s while Dr. D. L. Hollis continued as secretary. At its February 1943 meeting, the society was the guest of Colonel Strong, at the Gulfport Air Station Hospital. Minutes described it as one of the largest meetings the society had ever had. By the end of 1943, the membership was 75, including 61 in active practice and 14 in the Armed Forces. There were two honorary members, Drs. McArthur and L. C. Rouse. The society celebrated its 40th Anniversary on February 2, 1944, and dues had risen to $8.00 from the $6.00 imposed when the society was formed.

In the 1950s the meeting alternated between Gulfport, Biloxi, Pascagoula, Pass Christian, and Bay St. Louis. Drs. J. M. Howell, E. L. Bolton, and W. J. Weatherford were presidents during the early 1950s, followed by Drs. C. D. Taylor, H. Schmidt, F. C. Minkler, A. V. Hays, E. A. Trudeau and James T. Thompson.

Dr. Ray Foster was president in 1962 when the membership decreased the meetings to 6 times a year, in Bay St. Louis, Biloxi, Gulfport, Pascagoula, Pass Christian and a special November social meeting. In 1963 the society was the fourth largest in the state, with 129 active members, and 202 doctors practicing in the area.

The Pascagoula area had grown enormously by 1968 with the Ingalls Shipbuilding Industry and the Chevron Oil Company having been located there. In November the Singing River Medical Society was given a charter that separated Jackson County from the Coast Counties Medical Society. The Coast Counties Medical Society continues to represent the interest of medical practitioners of Harrison, Hancock and Stone Counties. ★★★

MSMA Leadership Is Family Tradition

PATSY SILVER

For many Mississippi physicians, medicine has been a family tradition; for three Mississippi medical families, MSMA leadership has been a custom. The list of past presidents of the Mississippi State Medical Association includes the names of three physicians who followed their fathers to the association's highest post.

The first to follow in his father's footsteps as MSMA president was Dr. Stanley Hill of Corinth (1959-60). His father, Dr. J. R. Hill of Corinth, was president in 1935-36. When Dr. Everett Crawford of Tylertown became president in 1965, he followed by some 20 years the presidency of his father, Dr. B. Lampton Crawford of Tylertown, the only man to serve two terms as MSMA president (1944-46). Completing the list of father-son presidencies are Dr. Lyne S. Gamble of Greenville (1976-77) and his father, Dr. Hugh A. Gamble of Greenville (1929-30).

The elder Drs. Hill, Crawford and Gamble have more in common than having been elected to the MSMA presidency and having been followed in that post by their sons. All have received recognition as outstanding men of medicine, and all have received tribute as respected citizens.

Dr. Jim Hill

When he addressed the MSMA House of Delegates on May 5, 1936, Dr. Hill called attention to some of the accomplishments of medicine in Mississippi, particularly the reduction in the incidence of certain preventable diseases. He called upon his colleagues to make preventive medicine the "watchword," stating, ". . . as long as the mortality rate from malaria, tuberculosis, typhoid fever, diphtheria and pellagra shows such inroads on our populace we should be up and doing until these preventative diseases are controlled." At the time of his death in 1963, time had demonstrated the success of that effort.

Dr. Hill was recognized as more than a perceptive medical leader, however. When he had been practicing medicine for 50 years, his colleagues and his neighbors in Corinth and Alcorn County paid tribute to him with a special celebration. An editorial describing that celebration in the November 1953 issue of *The Mississippi Doctor* observed, "He has served outstandingly as doctor citizen — a great factor in preserving the profession's noblesse. He has rightly appraised the importance of building a citizenship adequate to meet all problems. He has ministered to the physical needs of his people, shown them the way in mental development, and activated spiritual responsibility in his community. He has entered into the pleasures and joys and sympathies of his people. He has laughed with them, wept with them and counseled with them."

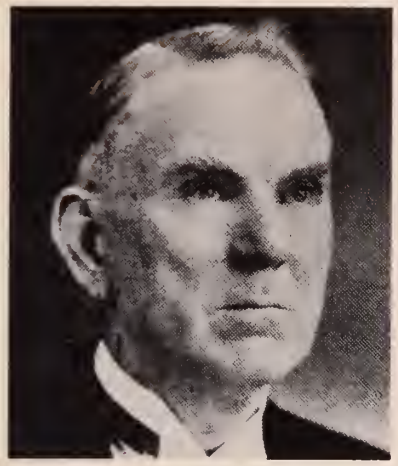
Dr. Jim Hill received his M.D. degree from the Memphis Hospital Medical College in 1903. He practiced in Kossuth for 20 years before moving his family to Corinth. In addition to serving as MSMA president, he served three terms as president of Alcorn County Medical Society and once as president of Northeast Thirteen Counties Society. He also served two terms in the Mississippi House of Representatives.

Dr. Stanley A. Hill

Stanley Allison Hill received his M.D. degree from the University of Tennessee College of Medicine in 1931 and established practice in his native Corinth in 1933. Like his father, Dr. Hill has long been active in his community's civic organizations and has devoted many years to active participation in professional societies.

Dr. Hill was president of Northeast Mississippi Medical Society in 1942; chairman of the Section on General Practice of Southern Medical Association in 1953; member of the editorial board of *Southern Medical Journal* from 1955-75; and president of the Mid-South Postgraduate Medical Assembly in 1963. In addition to serving as MSMA president, he has held many other posts in the association, including ten years as speaker of the House of Delegates (1948-58) and alternate delegate to the American Medical Association since 1963.

Formerly chairman of the Mississippi Commission on Hospital Care, Dr. Hill has been on the board of Blue Cross and Blue Shield of Mississippi since 1968. He was a delegate to the White House Conference on Aging in 1961. As chairman of the Alcorn County Hospital Building Commission, he was in-



Dr. Jim Hill
President, 1935-36



Dr. Lampton Crawford
President, 1944-46



Dr. Hugh Gamble
President, 1929-30



Dr. Stanley Hill
President, 1959-60



Dr. Everett Crawford
President, 1965-66



Dr. Lyne Gamble
President, 1976-77

strumental in the planning and development of Magnolia Hospital, which opened in 1965.

Dr. Hill has served as president of the Corinth Kiwanis Club and deacon in the First Presbyterian Church of Corinth.

Dr. B. Lampton Crawford

The expansion of the Walthall Hospital, which Dr. Crawford had opened in 1938, prompted an editorial writer in the *Tylertown Times* to remark in 1949, "the service Dr. Crawford is rendering the community can not be limited to his latest achievement, for over most of the past half-century this south Mississippi doctor has served this area as a medical man, a citizen and a leader. His story is more than that of the struggles of a small town county doctor in his efforts to safeguard the health of his community."

A fifty-year celebration for Dr. Crawford was held in Tylertown on June 14, 1953. An editorial in the December 1953 issue of *The Mississippi Doctor* stated, "Dr. Crawford, well-educated and balanced in judgment, is himself a great citizen-doctor, finely dividing health assets — physical, mental and spiritual. He has walked and advised with his people, coveted for them the best in medicine, carried it even to the one-room cabin. . . . For fifty years Dr. Lampton Crawford has served well in building a better citizenship for his town and county."

During his career in Walthall County he delivered more than 6,000 babies, and in 1938 he delivered more babies than any other physician in the state.

Dr. Crawford received his B.A. degree from Mississippi College in 1901 and his M.D. degree from Jefferson Medical College in Philadelphia, Pennsylvania in 1904. He began practice in Tylertown in 1906. In addition to his service in medical organization, he was active in many civic organizations and

in his church. For eight years Dr. Crawford served as a member of the Mississippi State Board of Health.

Dr. Crawford was the only man to serve two terms as president of the Mississippi State Medical Association. When he was inaugurated, he received the gavel from his brother, Dr. W. W. Crawford of Hattiesburg, who had served as MSMA president in 1906.

Dr. Everett Crawford

Everett Howell Crawford received his B.S. degree from Mississippi College in 1932 and the M.D. from the University of Tennessee College of Medicine in 1936. He served in the U. S. Navy from 1943 to 1946. Following a fellowship in surgery at Tulane University and Oschner's Clinic in New Orleans from 1946-1948, he entered practice in Tylertown.

In addition to serving as MSMA president, Dr. Crawford has been a member of the association's Board of Trustees and has served on the Council on Medical Service. He is a member and past president of the South Central Medical Society and a member and past councilman of the Southern Medical Association. He holds membership in the American Medical Association and the Southeastern Surgical Congress. In 1961 Dr. Crawford served as vice-president of the Mid-South Postgraduate Assembly.

Dr. Crawford is active in Tylertown civic organizations, and in 1977 he received the Service to Humanity Award presented by Mississippi College in recognition of his contributions in the field of medicine and his contributions to his community.

He is the eldest of three Crawford doctor sons. He and his brothers Walter and Ben are associated in practice in Tylertown. His son, Everett Howell Crawford, Jr., is a third-year student at the University of Mississippi School of Medicine.

Dr. Hugh A. Gamble

A memorial tribute to Dr. Hugh Gamble declared, "His devotion to loved ones, patients, and profession would fill one book, and his humble, never-ending search for the key to the mystery of life would fill another. Scientific research was second-nature with this man, and so was civic responsibility."

Another memorial observed, "His way of life was simple and can be expressed in one word, service. He was truly 'his brother's keeper,' giving freely of his time, his money and his surgical ability to all those who came to him, regardless of race, color or creed; and over the past forty-odd years in Greenville and in the surrounding Delta area the number who came to him for aid was legion. Not one was ever refused. He was a born physician, a doctor in the true sense of the word, his life dedicated to the care of the sick."

Dr. Gamble received his degree from Mississippi A & M College in 1898. Following service in the Spanish-American War as an enlistee with the Mississippi State National Guard, he received his M.D. degree from Tulane University School of Medicine in 1904. He interned at Charity Hospital in New Orleans, and opened his practice in Greenville in 1907.

In addition to his membership in the MSMA and Southern Medical Associations, Dr. Gamble was a member of the Southern Surgical Association and the Southeastern Surgical Congress. He was a founding member of the American Board of Surgery and of the American College of Surgeons. It was said that his chief professional interest was cancer, and in 1951 he received the First Distinguished Service Award from the Mississippi Division of the American Cancer Society.

His many years of service to his church and to Greenville civic organizations include 12 years as a member of the Greenville City Council.

Dr. Lyne S. Gamble

Lyne Starling Gamble received his M.D. degree from the Vanderbilt University School of Medicine in 1938. He served his internship and residency in ophthalmology at Charity Hospital of Louisiana at New Orleans, and did graduate work in ophthalmology at the Graduate School of Medicine at the University of Pennsylvania.

Dr. Gamble has been in practice in Greenville since 1942. He is a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology. He is a member of the American Medical Association, Southern Medical Association, Delta Medical Society, and he has held membership in the Mississippi Eye, Ear, Nose and Throat Association. He is a past president of the Louisiana-Mississippi O and O Society and former member of the MSMA Board of Trustees.

Dr. Gamble has been on the Board of Directors for Blue Cross and Blue Shield of Mississippi since 1975 and was a member of the Board of Directors of the Mississippi Foundation for Medical Care from 1975-80. Dr. Gamble served for 20 years as medical advisor of the local board of the Selective Service System and was a member of the Board of Directors for the Greenville YMCA. He is a member of the First Presbyterian Church of Greenville and has

served in the offices of deacon, elder and clerk of the Session.

His oldest son, Dr. Hugh A. Gamble, II, joined his father's group this year for the practice of thoracic and cardiovascular surgery.

Tradition of Service

The professional lives of Dr. Jim Hill, Dr. Lampton Crawford and Dr. Hugh Gamble spanned the first half of the 20th Century. It was a time of tremendous progress in the prevention and treatment of disease, and these three men witnessed and contributed to that progress.

The presidential messages delivered by these doctors at the conclusion of their terms had a common theme. They proudly recounted the progress in medicine and eagerly anticipated much progress to come. As Dr. Crawford concluded when he addressed the House of Delegates in 1946, "Preventive medicine dreams of the time when there shall be no unnecessary suffering and no premature deaths; when the welfare of the people shall be our highest concern; when humanity and mercy shall replace greed and selfishness; and it dreams that all these things will be accomplished through the wisdom of man. When young men have visions, the dreams of the old men come true."

On May 8, 1956, Dr. Howard A. Nelson of Greenwood told the House of Delegates, "His life has been an inspiration, his memory a benediction; for he felt and believed that it was still morning in American Medicine." Dr. Nelson was delivering the Distinguished Service Oration in memory of Dr. Hugh Gamble, but he might have been speaking of all three — "Dr. Jim," "Dr. Lampton," and "Dr. Hugh."

It was said of one of these early doctors, and it could be said of each, that "he instilled a vision for service" in his son. Those three sons who followed to the MSMA presidency have compiled records of accomplishments and service to continue the tradition established by their fathers. ★★★

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— From the 1887 *Transactions of the Mississippi State Medical Association*

From Chloroform to CT Scans — Doctors Recall Early Days of Practice

PATSY SILVER

THE YOUNG DOCTOR has just begun his practice of medicine. He has no office and no partners. In the county where he practices, there are no paved roads, and few are gravel. The doctor sees his patients in their homes at all hours of the day and night. He makes his calls, often as many as 20 a day, in a horse-drawn buggy or wagon. His black bag is equipped with few instruments and few medications other than quinine, calomel, aspirin, opium, morphine, and laudanum. His patients are ill with such diseases as typhoid fever, diphtheria, tuberculosis, tetanus, influenza and pneumonia, and he does what he can to relieve their suffering. If surgery is required, the patient is placed on the kitchen table, instruments are sterilized in a dishpan of boiling water, and chloroform is the anesthesia. Often the only light source is a kerosene lantern and the only heat source is a wood-burning stove.

Editorial Note: In preparation for this special anniversary issue, JOURNAL MSMA interviewed several Mississippi physicians to get their recollections about the early days of their medical practices. What emerged from the interviews was not only a graphic picture of the practice of medicine between the 1920s and 1940s, but also an image of the doctors themselves and their concerns about their profession.

For giving of their time and sharing their experiences, we are grateful to the following physicians: Dr. G. T. Sheffield of Gulfport, who began his career in general practice and psychiatry in 1917; Dr. Lamar Bailey of Kosciusko, a general practitioner and surgeon who began practice in 1925; Dr. Omar Simmons, who has practiced general medicine and surgery in Newton County since 1927; Dr. J. T. Thompson of Moss Point, who established his practice of surgery in 1939; and Dr. C. P. Crenshaw, a family physician who has practiced in Collins since 1946.

To many people, accustomed to hearing of sophisticated and commonplace diagnostic and treatment techniques such as CT scans, kidney dialysis and organ transplants, and having been cared for by numerous specialists in modern medical centers, the primitive scene described above seems hundreds of years in the distant past.

But Dr. G. T. Sheffield remembers those days. When he began his practice of medicine in 1917, the scene was a reality.

With just a few modifications (such as traveling in an automobile and having the miracle drug sulfa) the scene describes the early days of practice for a number of other Mississippi doctors — and as recent as 35 or 40 years ago.

Even after the automobile became the customary mode of transportation for doctors in rural Mississippi, the dirt roads were often impassable after rains. Dr. Bailey recalls that on many occasions it was necessary to have his car pulled out of the mud by a mule. Dr. Crenshaw kept containers of water in his car to wash the mud off the windshield, since the wipers did no good.

Dr. Crenshaw, like the other doctors, became very familiar with the roads in his area. "I knew every pig trail in Simpson County," he recalled, "and I learned which of the mud holes the car could get through without getting stuck just by getting a running start and sliding through."

Even after doctors established offices in town, they continued to see patients at home. Fees, according to Drs. Bailey and Crenshaw, were $1.00 or $1.50 for office visits, $2.50 for house calls, $25.00 for a tonsillectomy, and $25.00 for home delivery of a baby. The obstetrics charge, said Dr. Crenshaw, included prenatal and postnatal care in addition to delivery. Some patients complained about their bills, and non-payment of fees was a problem at times, although Dr. Crenshaw recently received payment for a bill which had been outstanding for more than 20 years. Far from being a romanticized fable, it is a fact that doctors did receive payment with things other than money. Dr. Bailey has a

ledger which documents that he and his physician father were paid with turkeys, hams, and watermelons.

It was not until around the year 1946, when communities began to build hospitals with the aid of Hill-Burton funds, that the logistics of medical practice in rural Mississippi underwent a dramatic change. Dr. Crenshaw recalled a time when he had a number of patients who needed treatment with penicillin. At the time the drug had to be administered every three hours around the clock. In order to treat all his patients, it was necessary for the doctor and his patients to check into the hotel in Collins, where he would set his alarm clock and make rounds during the night.

Descriptions of early days of practice in rural Mississippi were echoed by Dr. Sheffield and Dr. Simmons.

As dedicated as these country doctors were, they were not immune to discouragement. But when discouragement did appear, it was erased by the rewards, stated Dr. Simmons. He acknowledged that discouragement could be worse when attending an uncooperative patient in difficult labor after an already long and tiring day of making calls in the middle of winter. But the delivery of a healthy baby and the joy of a happy mother made it all worthwhile, he declared.



Dr. C. P Crenshaw



Dr. Omar Simmons

Progress in Medicine

Rather than dwell on the hardships and difficulties of their early days in practice, the doctors seemed to prefer to reflect on the advances of medicine since they began.

Dr. Sheffield recalled that when he began the practice of psychiatry, mental patients were locked up securely and mental care facilities had an oppressive air. He remembers the introduction of the first barbiturates, which occurred around 1922, when he was on staff at the state insane asylum in Jackson. The hospital had a standing order for Luminal® ($99.00 worth every 30 days) and epileptics were treated with the drug. It was around 1941, he recalled, that electro-shock therapy was advocated, and in the beginning it was used to treat most psychiatric disorders.

Dr. Thompson pointed out that when he was in medical school there were three specifics: digitalis for heart ailments, quinine for malaria and fever, and neoarsphenamine for syphilis. He took note of the remarkable advances in diagnostic aids, remembering that in the beginning of his practice there were few diagnostic techniques other than x-ray, electrocardiogram, blood count and urinalysis. The most important advance in treatment, he stated, was the introduction of antibiotics. He also recounted the tremendous strides in his specialty, surgery.

Dr. Bailey, a general practitioner and surgeon, pointed to strides which he has witnessed in anesthesia — from chloroform to the drop ether technique,

to the modern, safe, intravenous anesthesia drugs. When he thinks of progress in medicine, he recalls the prediction expressed by the physician who addressed his graduating class at Tulane Medical School. That doctor told the young physicians in 1925 that as they began their practices they would need a large medical bag and later, an even larger one; then, in a few years it would become smaller, and eventually they would be able to put it into their vest pockets. Dr. Bailey notes that the prediction has come true, and likes to say that he is a part of the "vest pocket age" of medicine.

"There will be as much advance in medicine in the next 30 years as there has been in the past 30 years," predicted Dr. Simmons. He expects that medicine will be as much a "new ball game" 50 years from now as his experience through the past 50 years has found it to be.

Time to reflect on the early days of practice and the opportunity to recount medicine's progress since those days produced thoughts and comments on other subjects:



Dr. J. T. Thompson

Specialization. The great body of knowledge seems to make increasing specialization necessary, agreed the doctors, but care must be taken to avoid the hazards of over-specialization. Several expressed concern that too many times the specialist is not in contact with the patient long enough to get to know him and develop a personal relationship. As urban areas become oversupplied with physicians, more specialists will go into rural areas, predicted Dr. Simmons, and "they will discover that there are opportunities there for a rewarding professional and satisfying personal life."



Dr. G. T. Sheffield

Medical Organization. Organized medicine has sought to accomplish many things for doctors and patients alike, and must continue those efforts. That seemed to be the consensus of the doctors interviewed. Throughout the span of years represented by these physicians, there were many battles fought on behalf of the profession, and some were unsuccessful. The collective belief in the importance of medical organization might best be illustrated by the fact that four of the five physicians have served as president of the MSMA. An experience related by Dr. Crenshaw demonstrates not only his early belief in the importance of participating in organized medicine, but also the growth of MSMA. At the beginning of his practice he attended an annual session of the association, where he was denied entrance because there was no record of his having paid dues. At the time there was no headquarters office, and association records were kept in a small box in the office of the physician who served as MSMA secretary-treasurer. Dr. Crenshaw sat on the steps of the Buena Vista Hotel in Biloxi for two days until word came that his dues payment had been found and he was permitted to attend the session.

Medical Education. Some of the doctors expressed regret at not having had the opportunity to pursue more advanced training at the beginning, but all agreed to the importance of continuing medical education for the practicing physician. Dr. Crenshaw's extensive collection of tapes has been a particularly good source of CME instruction, he said, and one he has little difficulty fitting into his busy schedule. Dr. Thompson expressed the opinion that some of the public relations problems which beset the profession might be prevented from the beginning if some demonstration of an attitude of caring and dedication were added as criteria for medical school entrance.

Advice to Young Doctors. More than anything else, there was expressed the hope that young doctors of today and tomorrow will establish personal, caring relationships with their patients. The key to this effort, the doctors declared, is to take time — time to listen and time to answer. It is Dr. Simmons' belief that often many patients have an emotional problem underlying their physical ailments, and a doctor can do much toward healing those persons if he takes time to listen and counsel. Many times, he says, the patient needs only to have a question answered. Dr. Simmons stated that with all the remarkable diagnostic aids that are available, it sometimes becomes too easy to wait for the test results. "When we began," he recalled, "we had to rely on our senses for diagnosis." He considers that sensitivity as another key to establishing a good doctor-patient relationship. As additional advice, several of the doctors said they would also caution young doctors to not permit the dollar sign to get between themselves and service to their patients.

Image of the Doctor. All acknowledged that there has been a decline in the image of the doctor, and all agreed that the general public does not seem to respect the profession as in the past. Lack of communication was often cited as a reason. Several stressed the importance of a physician's participation in community activities. The years of experience represented by these five physicians includes uncounted hours of service to their communities in civic and church activities. The honors that have been presented to these men by their communities expresses the esteem that their neighbors have felt for them. Commenting on the "image" problem, one doctor said, "It's not that doctors of today are not dedicated, but that somehow the public fails to see that they are." Communicating that quality of dedication was most important to restoring the image, he felt.



Dr. Lamar Bailey

Some people feel that the phrase "dedicated doctor" is in danger of becoming a cliché; but conversations with doctors such as these five makes the phrase become a reality. Hearing them describe their ideals provides an appreciation of their purpose; looking at their record of service produces evidence of their commitment; watching them at work gives proof of their dedication.

The interview experience with one doctor might best demonstrate that quality of dedication. Although some of the doctors interviewed are now retired, there is no doubt that this experience would have been typical of them all.

It was the doctor's afternoon off and the clinic was closed. Throughout our conversation he fully responded to questions and eagerly shared his memories. During the interview, the phone ran repeatedly. The staff had gone home, so the doctor answered the phone each time. With no complaints he counseled patients, ordered prescriptions, and cheerfully answered insurance questions. In the middle of the afternoon, a worried young couple appeared with their infant daughter and apologetically asked if the doctor could check the baby again. They appeared relieved and grateful when he terminated the interview in order to examine the child. At the time the interview ended, the topic under discussion was "public relations." ★★★

Auxiliary History Is Record of Service

PATSY SILVER

THE MSMA AUXILIARY's emphasis on stress management as an educational project in 1981 is part of a continuing effort to meet the goal adopted at the organization's founding in 1923.

During the 20th annual session of the Mississippi State Medical Association, 22 physicians' wives gathered in Vicksburg for the purpose of organizing a "Woman's Auxiliary to the Mississippi State Medical Association." The three-fold purpose adopted by the group was "to extend the aims of the medical profession through the wives of doctors, to the various women's organizations, which look to advancement in health and education; to assist in entertainment at state, district and county society meetings; to promote acquaintanceship among doctor's families that unity and harmony may be increased." The major emphasis of the founders was to spread health information in their communities.

A glance through *Torchbearers,* the history of the MSMA Auxiliary's first 50 years, reveals the extent to which the members have sought to express that emphasis. And much can be learned about the medical history of the state as well, since the health concerns of society have become the concerns of the auxiliary.

Led for three years by the first president, Mrs. Dan J. Williams of Gulfport, the women put their goal into action. First projects included the distribution to schools and libraries of a new popular health magazine *Hygeia* (renamed *Today's Health* in 1950) and support for the Child Health Camp in Biloxi.

Although flood relief became a special focus in 1927 due to the devastating Mississippi River flood, the young auxiliary also adopted other projects. Many members donated time to work for county health departments. The auxiliary encouraged birth registration; worked for control of communicable diseases, especially rabies and tuberculosis; and sought enforcement of state health laws. Special educational projects promoted better prenatal care.

Tuberculosis became the priority project of the auxiliary around 1929. It was then that the Preventorium was established on the grounds of the state Sanatorium. For many years the auxiliary endeavored to support the facility for tuberculosis-threatened children. Their work was successful even to the point of raising enough funds to have the Preventorium reopened in 1937 after it had been closed by the legislature.

Support for the Preventorium continued for many years, and during the war years beginning in 1941, other projects were added to the auxiliary's goals: civilian defense, Red Cross work, first aid and nutrition classes, blood bank aid and donor recruitment, and for the first time, cancer control.

At the end of the war, auxiliary reports indicated war participation had been the priority effort, with over 19,110 hours contributed to service projects by the members. The organization then turned to distributing literature on maternal and child health care and sending out information on the use of sulfa drugs and penicillin.



1925 MSMA Auxiliary Convention, Biloxi.



Auxiliary Leaders, 1931

Polio campaigns were among the priorities in 1949, along with cancer and tuberculosis projects. A new interest in rural health programs was begun at this time. The auxiliary also initiated nurse recruitment projects, which were to continue for some years. In the 1950s emphasis was placed on information about heart disease, education about safety in the home and automobile, and support for cerebral palsy victims. Added to the existing projects regarding polio, cancer and tuberculosis, the auxiliary members had expanded their health education efforts perhaps even beyond the visions of the founders.

Most of the previous health education efforts continued into the 1960s, along with a new emphasis illustrated by the 1960 theme — "Preserve and Enhance the Heritage of American Medicine." It was during these years that the auxiliary members began to work actively for legislation, and to spend many hours distributing messages regarding the dangers of federal regulation of the health care system. Late in that decade the organization added education about measles prevention to its growing list of projects. The 1960s ended with the nation's worst hurricane, Camille, which hit the Gulf Coast, and the auxiliary's chapters across the state responded with relief projects.

"Service in the Seventies" was the auxiliary's theme in 1970, a year which ushered in such projects as education about drug abuse and venereal disease. The need for such projects illustrated something of the changing nature of society at the time. A new project which appeared in the 1970s also demonstrated something of the remarkable advances being made in medicine, because the members developed projects to distribute information about organ donor programs.

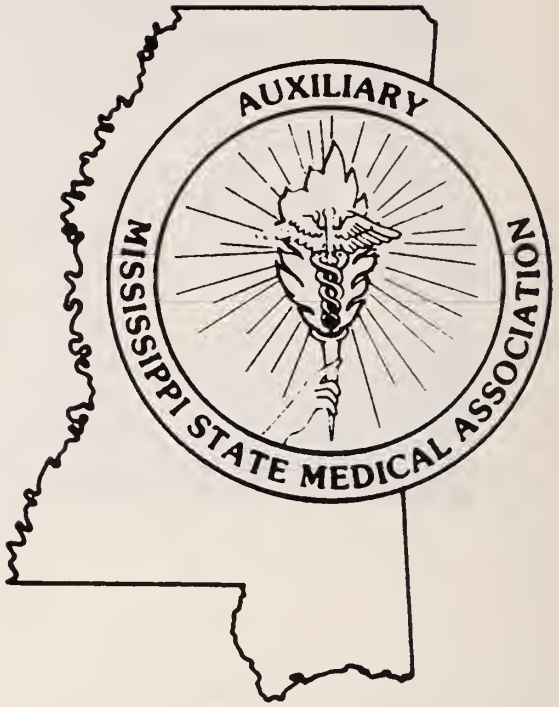


Children are pictured in one of the classrooms at the Preventorium, the state facility for tuberculosis-threatened children. Built in 1929, the institution was for many years the focus of MSMA Auxiliary support. The Preventorium was located on the grounds of the Mississippi State Tuberculosis Sanitorium.

AUXILIARY HISTORY / Continued

The 1980s began with the auxiliary's emphasis on fitness, with projects emphasizing individual responsibility in nutrition and exercise. This was a manifestation of the nation's growing concern with preventive health care. And in 1981, as stress has become a major concern of society, the auxiliary has responded with stress management workshops and the development of community educational projects on that subject.

As in past years, when the auxiliary's projects reflected society's "state of health" at certain periods of time, it may be assumed that auxiliary initiatives in the 1980s will continue to identify society's health concerns. Communities throughout the state undoubtedly will reap the benefits of auxiliary members' energetic efforts to carry out the purpose stated by the organization's founders. ★★★



The logo of the MSMA Auxiliary was designed in 1939 by Mrs. John Howell of Canton, yearbook chairman at that time. Her son, Dr. John Howell, Jr., sketched the design. The logo is said to symbolize the phrase, "We are the torchbearers of the medical profession," by picturing a caduceus converted into a torch which sheds light all around and is upheld by a woman's hand.

MSMA AUXILIARY PRESIDENTS

Mrs. Dan J. Williams, Gulfport	1923-25
Mrs. S. H. Hairston, Meridian	1925-26
Mrs. Sydney W. Johnston, Vicksburg	1926-27
Mrs. W. H. Frizell, Brookhaven	1927-28
Mrs. Harvey Garrison, Jackson	1928-29
Mrs. M. H. Bell, Vicksburg	1929-30
Mrs. L. L. Polk, Purvis	1930-31
Mrs. Mabel Mason, Lumberton	1931-32
Mrs. W. C. Pool, Cary	1932-33
Mrs. F. L. Van Alstine, Jackson	1933-34
Mrs. Henry Boswell, Sanitorium	1934-35
Mrs. Leon S. Lippincott, Vicksburg	1935-36
Mrs. A. G. Wilde, Jackson	1936-37
Mrs. C. C. Hightower, Hattiesburg	1937-38
Mrs. John B. Howell, Canton	1938-39
Mrs. Hugh Johnston, Vicksurg	1939-40
Mrs. E. C. Parker, Gulfport	1940-41
Mrs. W. K. Stowers, Natchez	1941-42
Mrs. V. B. Philpot, Houston	1942-43
Mrs. H. C. Ricks, Jackson	1943-44
Mrs. L. J. Clark, Vicksburg	1944-46
Mrs. Stanley Hill, Corinth	1946-47
Mrs. S. B. McIlwain, Pascagoula	1947-48
Mrs. James K. Avent, Grenada	1948-49
Mrs. Augustus Street, Vicksburg	1949-50
Mrs. W. H. Anderson, Booneville	1950-51
Mrs. George W. Owen, Jackson	1951-52
Mrs. Richard Clark, Hattiesburg	1952-53
Mrs. S. Lamar Bailey, Kosciusko	1953-54
Mrs. M. M. Snelling, Gulfport	1954-55
Mrs. R. Carter O'Ferrall, Jackson	1955-56
Mrs. Joseph B. Rogers, Oxford	1956-57
Mrs. A. E. Brown, Columbus	1957-58
Mrs. Mayo Flynt, Meridian	1958-59
Mrs. James T. Thompson, Moss Point	1959-60
Mrs. Lee R. Reid, Jackson	1960-61
Mrs. John G. Egger, Drew	1961-62
Mrs. A. T. Tatum, Hattiesburg	1962-63
Mrs. M. S. Riddell, Jr., Winona	1963-64
Mrs. Thomas J. Safley, Jackson	1964-65
Mrs. J. Hurd Gaddy, Long Beach	1965-66
Mrs. J. Gordon Dees, Jackson	1966-67
Mrs. D. L. Clippinger, Hazelhurst	1967-68
Mrs. Paul B. Brumby, Lexington	1968-69
Mrs. Louis Charles Lehmann, Natchez	1969-70
Mrs. Curtis Caine, Jackson	1970-71
Mrs. T. E. Ross, III, Hattiesburg	1971-72
Mrs. Clarence H. Webb, Jr., Jackson	1972-73
Mrs. William H. Preston, Jr., Booneville	1973-74
Mrs. Dan Reikes, Hattiesburg	1974-75
Mrs. J. Edward Hill, Jr., Hollandale	1975-76
Mrs. W. A. Brown, Jr., Mathiston	1976-77
Mrs. William Hilbun, Jr., Meridian	1977-78
Mrs. G. R. Rowlett, Jr., Vicksburg	1978-79
Mrs. Jim C. Barnett, Brookhaven	1979-80
Mrs. Curtis Roberts, Jackson	1980-81
Mrs. John Estess, Hollandale	1981-82

Public Health in Mississippi

ALTON B. COBB, M.D. and
W. E. RIECKEN, JR., M.D.

MISSISSIPPI'S HISTORY for nearly two centuries is dotted with landmarks in public health. In March 1799, just one year after the formation of the territory, Governor Winthrop Sargent signed into law an act entitled "A Law Concerning Aliens and Contagious Diseases," which was designed "to prevent the admission within the Territory of foreigners of infamous character . . . and to provide as far as possible against the fatal calamities of contagious diseases."

Although nothing was known in those early days about the manner in which germs were spread, and nothing was known of vaccines against typhoid fever, diphtheria, or any other disease except smallpox, several good health laws were passed.

Historically, Mississippi's public health programs have focused on prevention. Today's State Health Officer is responsible to the Board of Health and the people of Mississippi for planning and carrying out a comprehensive public health program which includes prevention and control of chronic and communicable diseases, maternal and child health services, family planning, environmental sanitation, environmental engineering, emergency medical services, and licensure of child care centers. The agency also operates the designated State Center for Public Health Statistics and provides public health laboratory services.

This comprehensive public health approach to "supervising the health interests of people" of Mississippi developed not overnight but through many decades of trial and error. This modern management system for the good health status of the state's people evolved through the diligent efforts of physicians, legislators, and others who not only followed but set trends toward the development of today's Mississippi State Board of Health.

Acts of the Territorial Assembly in 1803 and 1807 strengthened the 1799 laws; the acts prescribed quarantine measures against smallpox with penalties for willful disobedience.

Dr. Cobb is State Health Officer for Mississippi, and Dr. Riecken is medical assistant to the State Health Officer.

In 1818, one year after Mississippi became a state, the legislature approved an act which authorized the City of Natchez to establish a board of health to provide "for the more healthy police of the City of Natchez, and to provide against infectious and pestilential diseases." In 1822 the legislature passed a law relating to the sale of unwholesome food, and in 1823 the body provided that the justices of the county court should take measures as would best tend to secure prisoners from escape, sickness, and infection and to have the jails cleaned from filth and vermin.

An act passed in 1846 established at Jackson a vaccine depot and state agency charged with the prevention of smallpox. The governor-appointed agent was to procure and make available a supply of fresh and genuine vaccine, to vaccinate or revaccinate all who would apply to him for that purpose and to keep a record of all subjects vaccinated. This agent was to be a physician in good report for professional learning and skill and was to receive compensation in the amount of four hundred dollars per year. Whether the provisions of this law were ever put into effect is not known, but the principles outlined were much ahead of the day and remarkably similar to present plans for contracting for biological products, having them on hand for rapid distribution, having the health officer or physician vaccinate, and keeping proper records.

In 1857 the counties and towns were empowered to adopt such measures as they deemed expedient to "prevent the introduction or spread of yellow fever, smallpox, and other infectious diseases, and to prevent communication with persons or houses infected therewith." The Mississippi State Medical Association, which had been organized in 1856, supported this legislation and actively worked for the passage of health laws and the establishment of a state board of health.

The advent of the Civil War disrupted this progress in public health, just as it retarded all other development in Mississippi. History does not record any new health measures enacted from 1857 to 1876, but in March 1876, the legislature passed a

law which created a board of health for Hancock, Harrison, and Jackson counties. This board consisted of five physicians who were to select a physician to serve as quarantine physician and health officer in all ports of the state and in the three coast counties. The board was empowered to prescribe rules and regulations for the government and enforcement of quarantine and other sanitary measures which they deemed necessary and expedient.

The creation of the State Board of Health — essentially the product of the Mississippi State Medical Association — discloses the vision of the men who laid the foundation for the present structure. The *Transactions of the Mississippi State Medical Association* record statements in 1874 of the president, Dr. J. M. Taylor of Corinth, and in 1875 of his successor, Dr. P. F. Whitehead of Vicksburg, who recommended the establishment of a state board of health. An MSMA-appointed committee worked through the year 1876 toward applying to the legislature for the passage of an act to establish a state board of health; they presented a bill to the law-making body in its 1877 session.

On February 1, 1877, the legislature passed an act to create the Mississippi State Board of Health. The MSMA executive committee chairman, Dr. J. M. Taylor, reported to the association that the bill which the association had proposed "had been completely emasculated and radically altered before passage and the law as enacted was worthless to the State and illiberal to the profession."

The association continued to work for proper legislation. Amendments were made in 1878, and finally, in March 1880, all 21 sections were repealed and 24 sections passed in their place. This legislation was satisfactory to the association; no further amendments were made to the State Board of Health law for many years.

Fifteen physician members composed the first State Board of Health. The association nominated to the governor two members from each of the six congressional districts, and the governor appointed three members from the state at large. The board at its first meeting on April 7, 1877, elected Dr. Robert Kells, president and Dr. Wirt Johnston, secretary. Members of the board were appointed reporters on special subjects, and those reports were submitted during the next two years. At the December 1878, meeting, plans were made to institute the registration of vital statistics and inaugurate measures for the control of yellow fever.



Typhoid and diphtheria immunizations are administered at a plantation clinic in the early 1930s.

With the passage of the 1880 revised law for the State Board of Health, county health officers were nominated for 58 of the state's 82 counties. This action provided a mechanism for the implementation of the programs established by the board.

A law regulating the practice of medicine, with administration in the hands of the State Board of Health, was passed in 1882. The era of a statewide public health system had begun.

In 1888 the legislature authorized the State Board of Health to provide free vaccine for smallpox to regular practicing physicians in the state. This vaccine was to be distributed during the year and every three years afterwards. Compulsory vaccination of persons within five miles of a smallpox case was legislated in 1896. As a result of the yellow fever epidemic of 1898, the legislature strengthened the powers of the State Board of Health in the matters of quarantine against yellow fever and other contagious and epidemic diseases and established the duty of every practicing physician to report such diseases.

The year 1910 ushered in the modern era of public health in Mississippi. Dr. W. S. Leathers was appointed State Director of Public Health; the State Hygienic Laboratory was established; seven physicians were appointed to serve as full-time field directors; and the Rockefeller Commission provided funds to mount a statewide campaign against hookworm infestation. In 1912 the office of State Sanitary Inspector was created, and the Bureau of Vital Statistics was established. In 1913, the Board of Health authorized an annual meeting of county health officers, and the State Public Health Association was organized; 24 years later, in 1937, the membership was expanded to include all public health workers, and the organization became the Mississippi Public Health Association.

The legislature in its 1917 session changed the title of State Director of Public Health to Executive Officer of the State Board of Health and State Health Officer. Dr. Leathers continued in the post until 1924, when he resigned to become professor of preventive medicine at Vanderbilt University.

On the board's appointment, Dr. Felix J. Underwood became in 1925 the first full-time Executive Officer and State Health Officer for Mississippi. Under his leadership, public health continued to advance, and Mississippi soon became known nationally and internationally for its achievements in the field.

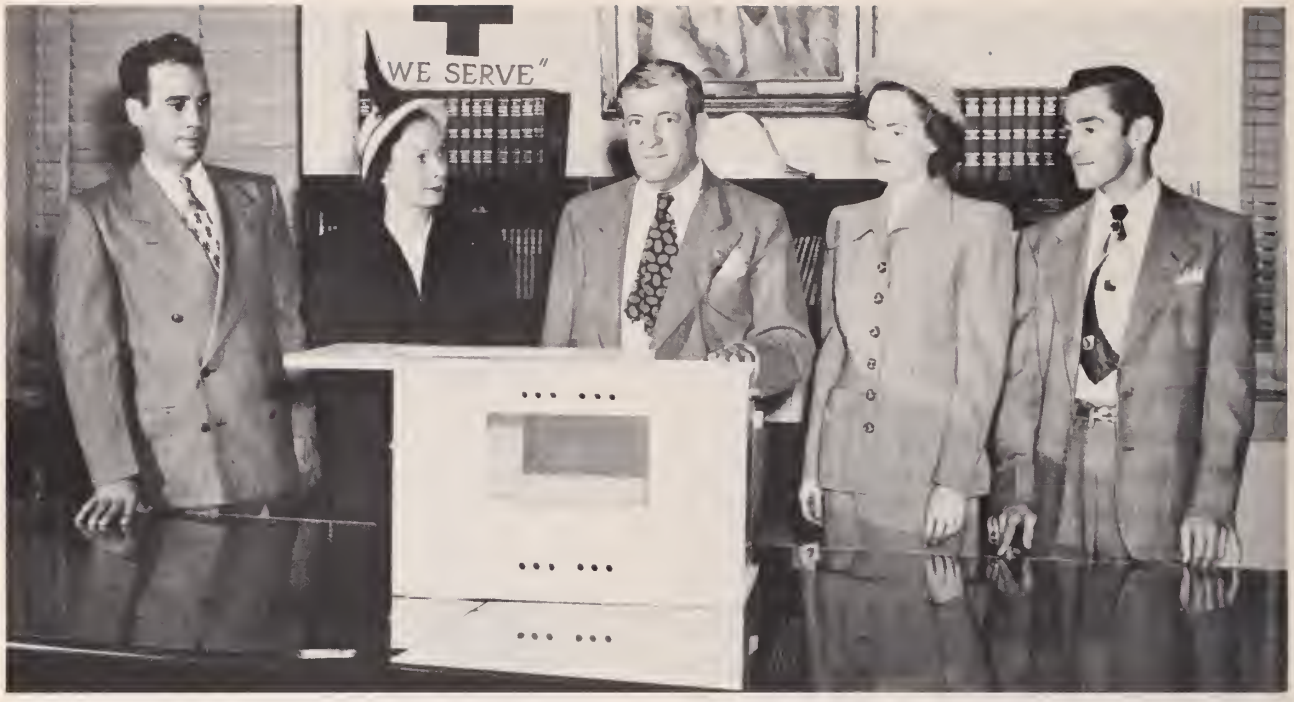
In 1915, Dr. Leathers had proposed the establishment of full-time county health departments with funding assistance for the first year's operation to come from the Rockefeller Foundation.



Harrison County in 1917 employed a full-time health officer and established a county health department. The results accomplished were effective, and that county has maintained a health department on a full-time basis since that date. It is the oldest existing full-time department in the state.

The real impetus for the establishment of county health departments came in 1920, when the legislature authorized each county or group of counties to create a department of health. During the formative stage, the State Board of Health from its central location in Jackson urged vigorous statewide campaigns against specific diseases; the board realized that to effectively combat diseases in a community, a local agency would have to perform the task. The full-time county health department was the agency of choice.

With assistance from the Rockefeller Foundation and the Commonwealth Fund, the development of county health departments proceeded throughout the 1920's and 1930's. By 1941, county health departments had been established in 63 counties of the state. World War II interrupted this development, but by 1953 every county had established a full-time health department (see map).



Above, Dr. Felix Underwood accepts an incubator for the Mississippi State Board of Health in 1949.
Below, in 1949 Dr. C. D. Taylor of Pass Christian and a nurse check premature quadruplets who were placed in Gordon Armstrong X-4 incubators on loan to the hospital from the Harrison County Health Department.





A group of public health nurses preview child health eduction materials during the late 1940s.

Mississippi's public health thrust has been toward prevention. Early emphasis was placed on the dreaded epidemics of smallpox and yellow fever; later, hookworm, typhoid fever, and syphilis were the major targets. Vaccines that became available for various diseases have been employed to reduce preventable diseases to a minimum, and the passage of the School Immunization Law in 1978 has given the state a 98.1 percent immunization compliance rate for children in kindergarten through grade 12.

During the 1930's, programs were developed to assist in the prevention of morbidity and mortality of pregnancy, child bearing, and infancy. These programs have been continued and have expanded with increasing knowledge and new techniques. Major efforts have been aimed at a sanitary environment, public water supplies, sewerage disposal, safe milk and food, and vector control.

In the past decades, emphasis has shifted from infectious diseases alone to include control of chronic diseases and a concern for the quality of life for all citizens. The shift from an agrarian to an urban, industrial society has produced new and complex problems in the health and environmental fields.

The State Board of Health concentrates efforts on such aspects of preventive health care as immunizations, family planning, hypertension control, sexually transmitted disease control, tuberculosis control, fluoridation, and services to high risk mothers and babies. State leadership has responded positively to offset and control potential environmental health hazards. Particularly emphasis has been required in the past decade in the critical areas of hazardous waste management and the protection of the public from harmful effects of ionizing radiation.

Legislative action in the 1980 session marked the first major reorganization of the State Board of Health in more than 50 years. The same legislation that reorganized the Board of Health created a separate State Board of Medical Licensure.



Public health nurses teach granny midwives in the 1930s.

As reorganized, the Board of Health includes 13 members, two from each congressional district and three from the state at large. The members are appointed by the governor with the advice and consent of the senate and serve staggered six-year terms. The newly reorganized State Board of Health re-elected Dr. Alton B. Cobb to a six-year term as State Health Officer.

The State Health Officer directs agency activities through four central office bureaus and six special offices, nine district offices, and 81 county health departments. Of the agency's 1,800 employees, 36 are physicians, and four are dentists. Local health departments rely heavily on local private physicians to provide medical services in the various clinics. This close relationship between public health and local private physicians has meant better and more effective medical care for the needy citizens of the state.

The real challenge of public health is in a continued commitment to improved health status for all Mississippi people. We must continue this public/private cooperation and turn a torrent of words on prevention into a commitment of public dollars to the kinds of cost-effective preventive and health promotional programs we have the knowledge base to implement during the 1980's. We must turn our policy makers at both the federal and state levels around to address the prevention of dental disease instead of hiring with public funds more dentists to fill teeth which should not have been cavity-filled. We must turn our prime enthusiasm away from chronic renal dialysis long enough to realize that adequate treatment of our young hypertensives would be a great deal more cost and health-effective. We must gain public understanding and support for community-wide coordinated efforts to control our rising tide of sexually transmitted diseases. We must assure a responsible public leadership serving an informed public. We must learn to put issues in proper perspective to make the best decisions for us all. ★★★

P.O. Box 1700 (39205)

Medical Education in Mississippi

JANIS QUINN

THE OPENING of the University of Mississippi Medical Center in 1955 was the culmination of hopes half a century old.

Medical educators on the Oxford campus were the first to realize that the two-year medical program was insufficient to meet Mississippi medical manpower needs.

"The program was undeniably excellent in the quality of its instruction," according to UMC vice chancellor and School of Medicine dean Dr. Norman C. Nelson. "The two-year school amassed an outstanding track record in the numbers of its students who were accepted as juniors into some of the country's finest medical schools."

Yet many of the students who left the state to finish their education never returned to practice. A survey in 1946 revealed the painfully obvious drain on one of the state's most valuable resources and a dire shortage of hospital beds as well.

The delay in obtaining a four-year school with a teaching hospital wasn't the result of any lack of foresight. As early as 1905, just two years after the first students enrolled in the Ole Miss medical program, faculty member Dr. Peter B. Rowland voiced the dream of a hospital training site to complete the basic sciences curriculum at Ole Miss.

"It is my deliberate judgment," he said, "that the legislature should construct a . . . hospital in . . . Jackson to be owned by the state, operated and controlled by the University of Mississippi, for clinical instruction, thus giving us a full four-year medical college in this state."

The school did have a site for clinical instruction in its grasp briefly in 1909 when officials offered the State Charity Hospital in Vicksburg to the University as a clinical affiliation.

Chancellor Andrew Kincannon jumped at the opportunity. He gathered five professors and nine assistants for the Vicksburg experiment to teach five juniors and three seniors for the academic year 1909-1910. But lack of money and equipment cut the attempt short, and after a year, the idea was abandoned.

From the Department of Public Relations and Information Services, University Medical Center, Jackson, MS.

In the late 1940's, the Mississippi State Medical Association, Governor Thomas Bailey, and interested legislators and educators began seeking support for a four-year medical school. They had little luck then, but they set the stage for the 1950 legislative session during which Rep. Zelma Price of Greenville was wheeled onto the floor of the House of Representatives on a stretcher to cast a yea vote for the establishment of the Medical Center. She was joined in enough affirmative votes from both houses to pass the legislation authorizing the expansion of the medical school and the building of the teaching hospital in Jackson.

Appropriated funds amounted to $4 million at first, a half-million later. To that sum was added $3 million in Hill-Burton money and $1,500,000 from Hinds County.

The first director of the Medical Center and the first dean of the four-year school, the late Dr. David S. Pankratz, often said, "Getting the legislature to vote for the school was a struggle, but I don't know of any medical school in the country that came easy."

The main concern of the legislators then was money. Could the state afford the large yearly expenditure it would take to operate the Medical Center? Supporters of the four-year school asked a different question: Could Mississippi afford not to have its own medical school?

When bricks and mortar were formed into the seven-story, three-wing, T-shaped building on the site of the old state insane asylum and when the core faculty had been assembled from around the country, it was the beginning of an adventure long hoped for by many people. But if any one person could be credited with the institution's existence, it is Dr. Pankratz, who had become dean of the two-year school in 1946. Dr. Thomas J. Brooks, Jr., one of the original chairmen who retired this year from the Department of Preventive Medicine, recalls that Dr. Pankratz "wore out two Desotos" traveling the state, drumming up support for the proposed Medical Center.

Ole Miss chancellor emeritus John D. Williams said Dr. Pankratz's flair for identifying and bringing in aggressive promising young people was the key in the Medical Center's rapid growth. During the six-

year tenure of the first dean, the medical school earned accreditation, funds were secured for a research wing, and four classes of MDs — the first ever trained entirely at home — were graduated.

It took $4,500,000 to run the place the first year of operation. Today's budget is more than $114,000,000. There were 166 students in 1955, including 135 medical students, two graduate students, 14 interns, 12 residents and three who audited classes. This fall, total enrollment is 1680, with 600 in the School of Medicine. The creation of the four-year school and teaching hospital provided the nucleus for a major health sciences center which now includes the Schools of Nursing, Health Related Professions, Dentistry; graduate programs in the basic sciences; postgraduate training for residents and fellows; and certificate programs for a variety of allied health professionals.

Clinical instruction site for all students is University Hospital. In its 26-year history, the hospital has served 2.6 million patients, a figure which approximates the total population of the entire state.

Square feet under roof in 1955 totaled 473,379. Now the Medical Center covers 1,501,072 square feet, or 34½ acres.

Every year, the institution becomes increasingly complex; the pace on the 155-acre campus is always a little quicker than it was the year before; numbers keep spiralling upwards.

But the Texas-like statistics — 4,000,000 pounds of linen washed and 45 tons of breakfast eggs cooked in a year's time — are really only footnotes in the history of an institution fulfilling its original charter: to train health professionals for Mississippi, to tend the sick, and to foster research.

The Medical Center has graduated 2110 physicians since 1955. Programs to encourage their permanent location in Mississippi and the proven phenomenon that physicians generally practice where they train has combined to produce a substantial increase in the state's physician population. Before the Medical Center opened, 1449 physicians practiced in state; 42 percent of that number were over 60. In 1981, according to MSMA figures, there are 2527 MDs practicing here.

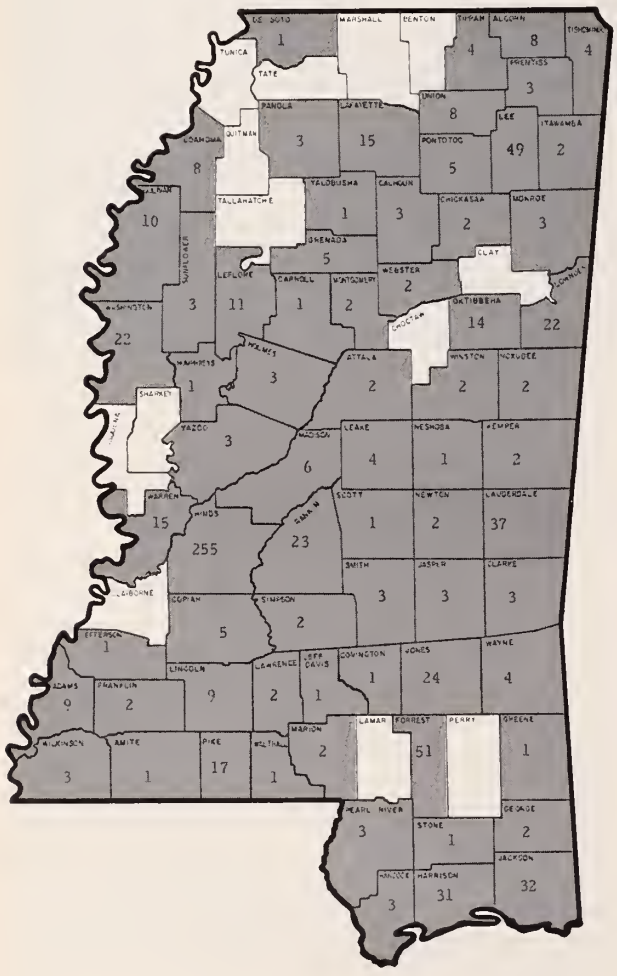
"Of the physicians who have earned degrees here and who have completed all training, two thirds are practicing in the state," said Dr. Nelson. "We're enormously proud of that retention rate. It easily betters the national average for state supported medical schools."

The school's graduates practice in 108 of the state's communities and in 69 of its 82 counties. They represent all of medicine's specialties and a good number are family physicians. Some are family medicine preceptors who teach students in their practices under the auspices of the Department of Family Medicine.

Dr. James D. Hardy, chairman of the Department of Surgery, since 1955 recalls that there were only a few board certified surgeons in any specialty in the state when he came here from Tennessee 26 years ago. "Now you can't find a town of any size at all that doesn't have at least one well qualified surgeon and usually more. The impact of this institution on the state has been tremendous."

Dr. Hardy is one of the original department heads still in the chair. Others are Dr. Arthur C. Guyton, physiology and biophysics, Dr. Blair E. Batson, pediatrics, and Dr. Warren N. Bell, clinical labora-

SCHOOL OF MEDICINE FOUR YEAR GRADUATES



Some two-thirds of the School of Medicine graduates who have finished all training and are in practice are in Mississippi – in 108 communities and cities in 69 of the 82 counties.



Dr. David Pankratz with registrar Lallah White at the Medical Center's first registration in 1955.

tory sciences. Dr. Brooks retired in July 1981 and Dr. Robert D. Sloan, radiology chairman in 1955, stepped down as department head last year but still teaches in the department.

They and seven others, including Dr. Pankratz and Dr. Williams, received special recognition for their exemplary leadership during the institution's 25th anniversary year in 1980. Others honored were Judge J. P. Coleman, chief justice of the fifth circuit district of the United States Court of Appeals, Elizabeth Graves, professor emeritus of nursing, Dr. Charles Randall, microbiology department chairman from 1957-1978, Dr. Louis Sulya, first biochemistry department chairman until his retirement in 1977, and Dr. David Wilson, first director of University Hospital.

Dr. Nelson, the fifth man at the Center's helm since 1955, has guided the institution since 1973, perhaps the period of most burgeoning growth. In that time, the Center has added the clinical sciences wing, the dental school and classroom addition, the library/learning resources center, and the acute services wing, scheduled to open in April, 1982.

Leadership has come from other arenas, too. In 1956, Judge Coleman, then governor, appointed Dr. Verner S. Holmes, a McComb otolaryngologist, to the Board of Trustees, Institutions of Higher Learning. Other board members had requested a new appointee to help them interpret the needs of the new Medical Center. Dr. Holmes served 24 years — two terms — on the board, the longest tenure in the board's history.

Dr. Holmes recalls what his first meeting on the board was like. "I had made up my mind, I was just going to listen and keep quiet, not say a word, because I figured I needed to learn some things."

But another board member suggested that the new four-year medical school accept students with low grades because it was his opinion that they would be the ones most likely to practice in Mississippi's small towns.

"Well, I just hit the ceiling when he said that," Dr. Holmes recalls. "I said, 'Don't you think people in little towns deserve good doctors just as much as the folks in the big cities?' It just didn't make sense, and I just couldn't sit still and say nothing."



Above, the vacant site of the proposed four-year medical school where the state insane asylum once stood. Building in the lower right is Bailey Junior High school at North State Street and Riverside Drive. St. Dominic Hospital is at upper right.

Below, today's Medical Center – with 34½ acres under roof.





Dr. Norman Nelson on the construction site of the acute services wing with construction supervisor Dave Davis.

Those first comments by Dr. Holmes, setting the tone for his long tenure, fell on appreciative ears at the Medical Center. The remarks were a true barometer of his feelings about excellence in medical education, and a succession of Medical Center administrators came to rely on the man's unfailing commitment to high standards.

The tradition of high standards also has put the Medical Center at the forefront of scientific investigation. Research into the transplantation of organs began almost as soon as the first labs were outfitted in 1955, culminating in the world's first heart and lung transplant in man. Likewise, the physiologists at the Medical Center were studying body function by mathematical analyses as early as 1955 and simply waited for the computer technology to multiply and store their computations. Today, with a growing interest in the computer simulation of body function, the institution is looked to as a world leader in the field. It was a Medical Center physician who was the steering committee chairman for the landmark Hypertension Detection and Follow-up Program by the National Institutes of Health, the study which once and for all, proved the efficacy of treating mild hypertension.

The institution's research effort is suppoorted by more than $13 million in grants and contracts. Projects cover a broad range: the effects of hard water minerals on hypertension and atherosclerosis, how the body reacts to mirex, determining how genes in identical cells code for completely different functions, the implantation of artificial tracheas, the effects of television violence on children's behavior, and a continuing look at the herpes virus group and its link to cancer.

"Our primary reason for existence is the education of health professionals," Dr. Nelson said. "But no institution of this kind can excell at teaching unless it also conducts a vigorous research program and demonstrates excellence in patient care. The three activities have a symbiotic relationship, and the failure of one inevitably leaves one or the other bereft.

"Those three components are the focal points of our mission in state higher education today just as they were in 1955. A dynamic institution, such as this Medical Center has proven to be, is subject to change and growth — change in people, growth in numbers. But as surely as things change, the base upon which we stand remains the same: our commitment to respond to the health needs of Mississippi."

2500 North State Street (39216) ★★★



The President Speaking

Happy Birthday MSMA

R. FASER TRIPLETT
Jackson, Mississippi

This issue of JOURNAL MSMA recognizes the 125th birthday of the association and appropriately recalls some of its long history of service to our profession and the public we serve.

It all began on December 15, 1856 when a few physicians met in Jackson, adopted a constitution and by-laws, elected a president, and appointed delegates to the American Medical Association.

They were a dedicated and public spirited group. Their ensuing efforts to improve the profession, community, state and nation in the midst of civil war, pestilence and general public ignorance about good health made them giants among men. Some of their earliest accomplishments were the establishment of a State Board of Health in 1877 and enactment of a medical practice act in 1882. In 1903 they joined with their professional colleagues throughout the country to organize a federation of state and county medical societies we know as the American Medical Association today.

They met with opposition more often than not, but it did not deter them. Their initial recommendations for the State Board of Health were "completely emasculated" by the legislature. Their proposal for a more stringent medical practice act was opposed by many of their colleagues and "allowed to sleep" for a few years in the Senate Committee on Judiciary. It took several years to organize county medical societies in accordance with the plan of the AMA approved at their 1903 meeting.

Their practice of medicine relative to now was much more "art" than science. They were victims of many of the dread diseases they attempted to treat. For example, a report in the *Transactions* of a meeting of the association in 1879 indicates that 20 percent of the membership died of yellow fever during 1878.

Much has transpired since that first meeting of the association on December 15, 1856. But the goals of the profession to advance the art and science of medicine and to improve the public's health through this association have remained constant. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XXII, Number 12

DECEMBER 1981

Guest Editorial

Old Volumes Provide Links With Medicine of Today

When asked to review the transactions of MSMA for the years 1885-86, 1892-93 and 1901 to obtain a picture of medicine as practiced in that era, I was fully prepared to wade through the musty-smelling, yellowed pages to glean an item or two that might have passing interest to the profession of today — a chore I rather dreaded. To my intense surprise I found myself scanning the carefully edited pages with a mounting interest. Suddenly I realized why I was probably picked for this job — my age! My parents were married in 1901 and I came along eighteen years later. So instead of trudging through long-past material with no connecting links with the medicine of today I came upon a steady stream of them that have touched my life and the lives of my peers — the advertisements, the names, the articles and even the editorials.

Sharp and Dohme plugged their saccharated pepsin prepared from the stomach of the hog and free from unpleasant odor and taste in 1885. I have dusted and wiped many a dispensing bottle of this and other similar preparations behind the prescription glass of my father's drug store, even remembering the medicine-smell! Wonder what the FDA would have done with this one.

In the ad of the Medical Department of the Tulane University of Louisiana, I find the matriculation fee is $5.00, but the tickets to the professor's lectures were $140 and the "Demonstrator" of Anatomy was Rudolph Matas, M.D., who was still active when I entered medical school. The Jefferson announcement boasted such names as DaCosta and Pancoast. Bellevue Hospital Medical College listed Austin Flint and Janeway.

I was amazed to find that Dr. P. W. Rowland of Coffeeville in 1885 was Dr. Peter Whitman Rowland, or "Bunny Rabbit," who taught pharmacology at Ole Miss when I was a freshman. *I* didn't call him by his nickname. I only heard the medical students call him that — like Charles Neill and Ralph Sneed!

J. A. Crisler practiced in Flora in 1892, then in Yazoo City in 1901. Now I wonder if he went on to Memphis with Dr. J. B. McElroy ("Big Jim"), who taught me in his last year at UT ('36) and Dr. Eugene Johnson who was still operating! They were both in Yazoo City at one time, because Dr. Johnson came from Yazoo City to Goodman (where I grew up) in a buggy and operated on my uncle, a young doctor in his first year of practice at Thomastown who had a perforated typhoid ulcer. As our cerebral perfusion diminishes our nostalgic urges increase!

At the meeting in 1892 in the Senate chamber, Bishop Galloway offered the opening prayer. The only way we get in there now is to be Doctor of the Day or have another Cliff Finch hearing!

In 1893, there were *16* active practicing physicians in Holmes County. Now we have half that number. But then Hinds County had only 22. How's that for centralization of power!

In reviewing the scientific (?) presentations, one is stuck by the courtliness of the prose. Do you know of one *courtly* Mississippi Doctor? Even if what they wrote about is, yes, primitive, their sincerity and dedication came through; and now that we have an armamentarium that would astound them, I fear we have lost something in the process. Not patients, for our mortality rates are most impressive, but for lack of a better word our "image" is dwindling while we fondle our lab reports and order in milli-equivalents with the malpractice lawyers hovering in the wings.

114th Annual Session May 2-6 Biloxi
Celebrating MSMA's 125th Anniversary

(EDITORIAL/Continued)

As our fees rise to astronomical heights, I hope somebody has the answer to all this, I surely don't. They didn't get sued and they treated — I'm quoting — things like malarial flux, puerperal nephritis, menstrual epilepsy, permanent headaches, la grippe and urinary fever with what we now would consider nostrums such as veratrum viride, gelsemium sempervirens, euphorbiaceae, aqua camph, ol. terebinth, spt. nit. dulc., and caustic potash.

Though I wince at some of their therapeutics, I bow in deep reverence to our forbears in this state as they blazed a trail we have all followed.

A. A. Derrick, Jr., M.D.
Durant, Mississippi

LETTERS

Dear Faser: I understand that December 15, 1981 will mark the beginning of the Mississippi State Medical Association's 125th anniversary year. Enduring so long is an achievement in itself, but for an organization to make the contributions that the MSMA has to this state and her people merits exceptional recognition. You and others who have served the association in leadership roles over the years deserve enormous credit for building the organization into the superb professional body it is.

I also want to take this opportunity to express the University of Mississippi School of Medicine's appreciation, indeed the entire university's gratitude, for the association's continuing support of and interest in the health sciences campus. The association's very strong support of a four-year medical curriculum helped make this School of Medicine a reality; your continuing commitment to our common goal of excellence in medical education has helped this school become one of the finest in America in less than three decades.

Thus during the historic anniversary year, I hope all of our colleagues will recall the establishment of the School of Medicine and take pride in that achievement. Certainly it deserves a special place in the association's long and distinguished history.

My heartiest congratulations to all of you.

Sincerely yours,
Norman C. Nelson, M.D.
Vice Chancellor for Health Affairs
Dean, School of Medicine

Dear Dr. Triplett: What an honor to serve as president of a prestigious organization such as the Mississippi State Medical Association and particularly during its 125th Anniversary.

The accomplishments of the State Medical Association over the years have been innumerable. The dedication of physicians in Mississippi having the foresight in promoting programs and services to benefit all Mississippians through the Medical Association is well documented. In addition, MSMA has been a leader in advancing the concept of private enterprise in the practice of medicine and delivery of health care.

The 120 member institutions of the Mississippi Hospital Association have enjoyed the close working relationship with the MSMA and look forward to the continued cooperation between the organizations in promoting quality health care in Mississippi.

Sincerely,
Sam W. Cameron, President
Mississippi Hospital Association



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2. That many non-M.D. practitioners are seeking the right to practice medicine through legislative action without attending one day of medical school?
3. That the groups that traditionally do battle with medicine in congress and the state legislatures are giving, and giving heavily, to defeat candidates who support our views?
4. That one way to stem the rising tide against medicine is to join the Mississippi Medical Political Action Committee and the American Medical Political Action Committee?
5. That less than half the MSMA members belong to MMPAC and those who do belong are "carrying the load" for those who don't belong?
6. That a sustaining membership in MMPAC and AMPAC costs only $100.00 a year and that is less than the price of one Coke a day?
7. That you can be a part of the growing number of Mississippi physicians who have recognized the need for effective political action by paying MMPAC/AMPAC dues when you pay your MSMA dues or by sending a check to MMPAC, P. O. Box 5229, Jackson, Mississippi 39216?

MMPAC AND AMPAC ARE DOING THEIR BEST TO HELP YOU.
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An individual is free to contribute more or less than suggested and neither AMA nor MSMA will favor or disadvantage anyone based on the amount of or failure to contribute. MMPAC and AMPAC voluntary contributions may be used in connection with a federal election and are subject to the prohibitions and limitations of the Federal Election Campaign Act.

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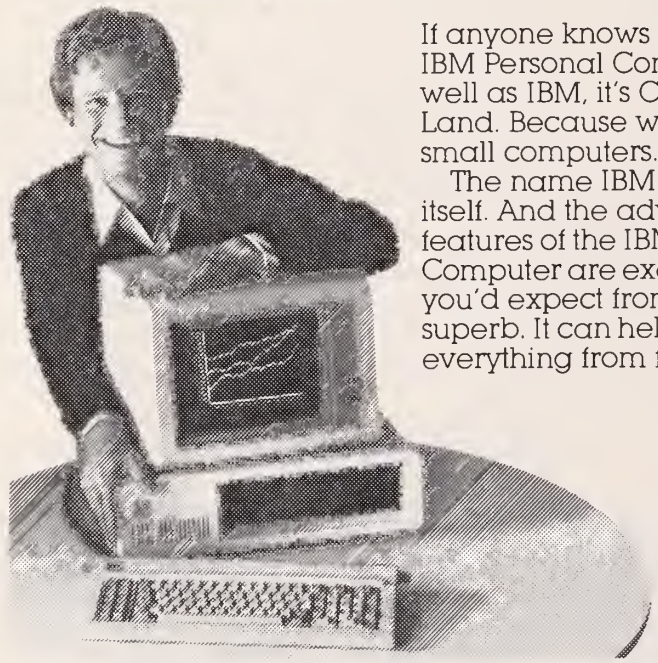
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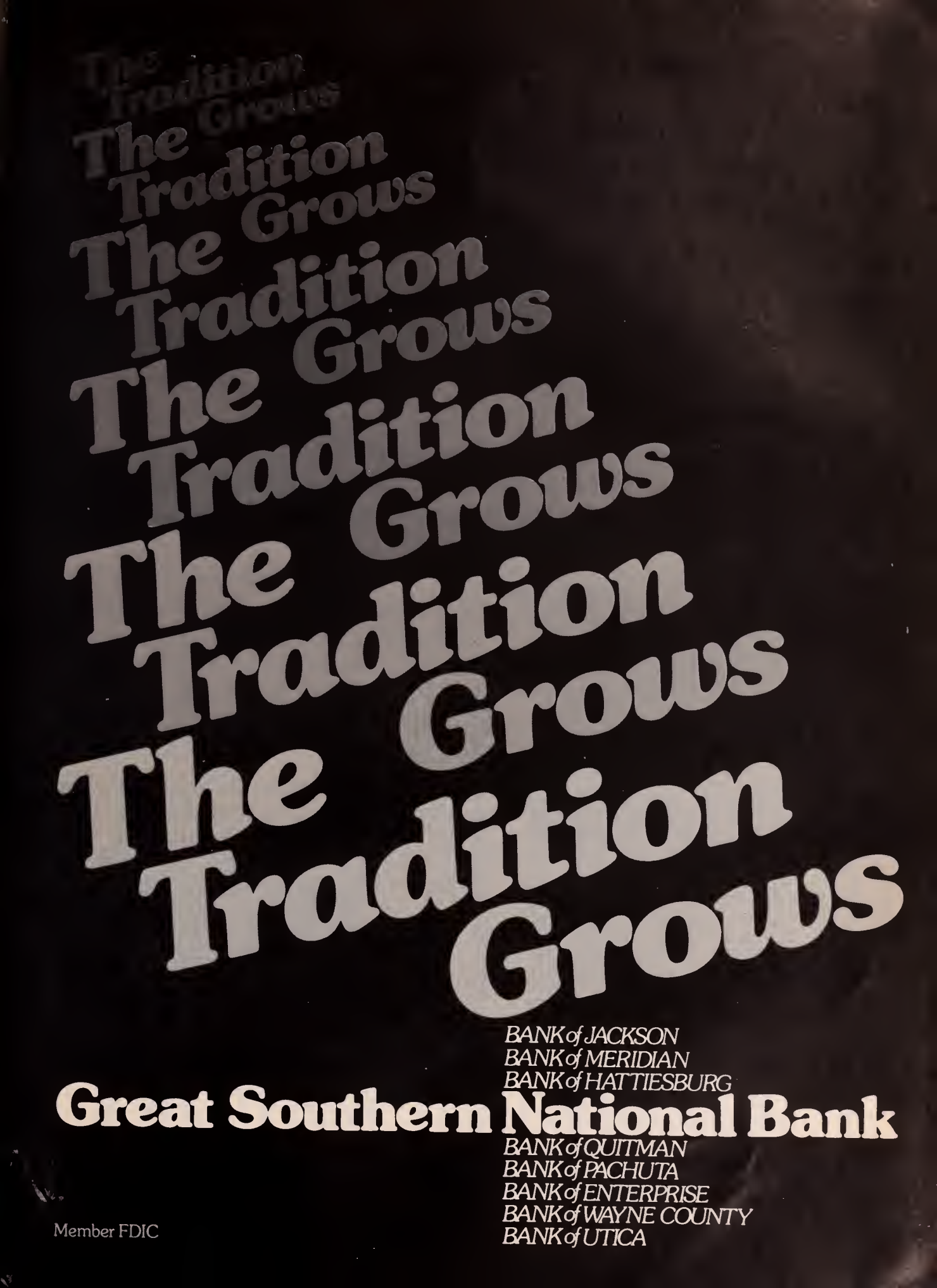
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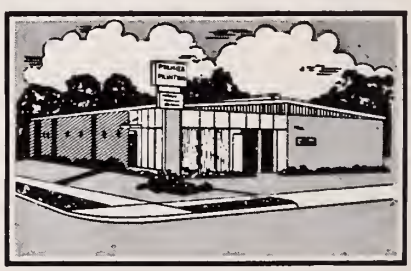
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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 13-17, 1982, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi State Medical Association, 114th Annual Session, May 2-6, 1982, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 30-July 3, 1982, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

POSTGRADUATE CALENDAR

Jan. 16, 1982
ENDOCRINOLOGY OF THE AGING WOMAN
The Jackson Regency, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: G. William Bates, MD, associate professor of obstetrics and gynecology.

This seminar will present current concepts of menopause and emphasize indications and contraindications for hormonal replacement therapy. The physiology of ovarian failure and pathophysiology and estrogen deficiency will be covered. Fee: $30. Credit: 3.5 credit hours in Category I of the AMA Physician's Recognition Award; AAFP credit applied for.

Jan. 23, 1982
PHOTOGRAPHY FOR EDUCATION AND SLIDE PROGRAMS
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Dentistry and the Medical Center Division of Continuing Health Professional Education.

Coordinator: William B. Akerly, DDS, UMC associate professor of restorative dentistry.

This program is open to physicians, dentists, teachers and hobbyists. Sessions will focus on macro-lens and close-up photography. Films, filters and reverse-text production techniques will be covered. Methods for graphic illustration and copying, such as polarization, glass supports and background materials, also will be demonstrated as a means for making effective title or lecture slides. Fee: $50.

Feb. 4-5, 1982
RENAL UPDATE
Ramada Inn Coliseum, Jackson

March 11-13, 1982
SURGICAL FORUM IX
Holiday Inn Downtown, Jackson

March 25-26, 1982
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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

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Pregnancy
See "WARNINGS"
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PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

SURGEON seeks location in general thoracic and cardiac surgery upon completion of residency in July, 1982. Graduate of Tulane University, 1975. Contact Dr. Kevin M. Keubler, 600 Highland Ave., Madison, WI 53792.

PATHOLOGIST — Board Eligible. University trained. Completing residency. Available July 1981. Contact Ashraf Mohammad, M.D., University Medical Center, 2500 North State St., Jackson, MS 39216.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

GENERAL PRACTITIONER seeks practice location in small community. Contact Keith Hummell, M.D., 405 Mesaba Ave., Apt. 5C, Duluth, MN 55806.

OPHTHALMOLOGIST seeks practice location upon completion of military service in January 1982. Contact John R. Wood, M.D., 8430 Rocky Path, San Antonio, TX 78250.

BOARD ELIGIBLE INTERNIST seeks practice location; M.D. from University of Texas at Southwestern. Contact Stephen R. Cherry, M.D., 7061 B Creekview Trail, St. Louis, MO 63123.

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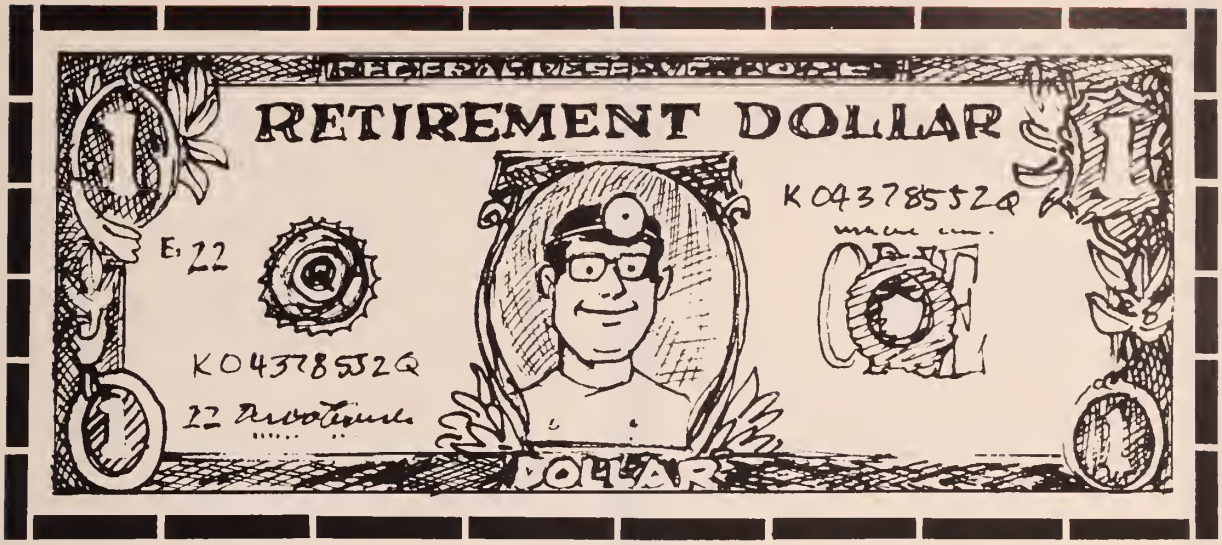


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SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "MLB," Medico-Legal Briefs; "AP," Auxillary Page; "PM," Practice Management Mailbox; the asterisk (*) indicates an original article in the Journal, and the author's name follows the entry in brackets. "Deaths," "Personals" and "New Members" are indexed under the letters "D," "P," and "M" respectively.

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose of in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

Note: Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1 Antimicrob. Agents Chemother., *8*: 91, 1975
2 Antimicrob. Agents Chemother., *11*: 470, 1977
3 Antimicrob. Agents Chemother., *13*: 584, 1978
4 Antimicrob. Agents Chemother., *12*: 490, 1977
5 Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978
6 Antimicrob. Agents Chemother., *13*: 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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succeeds

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Expanding its usefulness in antimicrobial therapy



in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, pleese consult complete product informetion, a summary of which follows:

Indicetions end Usege: For the treetment of urinery trect infections due to susceptible streins of the following orgsnisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgeris, Proteus morganii.* It is recommended thet initiel episodes of uncompliceted urine.y trect infections be treeted with s single effective entibecteriel egent rether then the combinetion. *Note* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For ecute otitis medie in children due to susceptible streins of *Haemophilus influenzee* or *Streptococcus pneumoniee* when in physicien's judgment it offers en edventege over other entimicrobiels. Limited clinicel informetion presently eveileble on effectiveness of treetment of otitis medie with Bactrim when infection is due to empicillin-resistent *Haemophilus influenzae*. To dete, there ere limited dete on the sefety of repeeted use of Bectrim in children under two yeers of ege. Bectrim is not indiceted for prophyiectic or prolonged edministretion in otitis medie et eny ege.

For ecute execerbetions of chronic bronchitis in edults due to susceptible streins of *Heemophilus influenzae* or *Streptococcus pneumoniae* when in physicien's judgment it offers en edventege over e single entimicrobial egent.

For enteritis due to susceptible streins of *Shigella flexneri* and *Shigella sonnei* when entibecteriel therepy is indiceted.

Also for the treetment of documented *Pneumocystis carinii* pneumonitis. To date, this drug hes been tested only in petients 9 months to 16 years of age who were immunosuppressed by cencer therepy.

Contreindicetions: Hypersensitivity to trimethoprim or sulfonamides, patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age

Wernings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Preceutions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions.* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions.* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosege. Not recommended for infents iess than two months of ege.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment. Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage. 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100. Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE®
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Bactrim™ succeeds

in recurrent urinary tract infection



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NEW YORK N.Y.
10029

from site to source

Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303* 426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

NEW YORK ACADEMY OF MEDICINE

maximizes results with B.I.D. convenience

ROCHE®

* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

The New York Academy of Medicine

DUE IN 4 WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 8 WEEKS

DATE BORROWED	BORROWER